Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:48 A.M April 2008 Roy F. Wernly /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ★ M 2 □ F 83 Yrs Director 325-20-2120 12. 1924 IL Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 6 United States 20878 217 Booth Street Apt 230 A or items 23a Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Eximiner once. 1 M Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married WW II Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Plant Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfrieda Lindblom Fred Wernly ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 217 Booth Street Apt 230A, Gaithersburg, MD 20878 Marian E. Wernly -Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3】【Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 11 2008 Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service License 1 RACUA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 24hrs **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 4 🗹 Unknown 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy pertorme 10 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 _Hnpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this 27. Man of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

10+1

Registrar
DHMH 17 Rev 1/2001

State

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)

2008

S1440

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31. Date filed (Month, Day, Year)

08

Dennis C. Friedman M.D.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0845 AM **Physician** Betty Kay WILHIDE 15 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hagerstown Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day,)
July 24, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Year) 1 □ M 2 Pennsylvania 1954 53 218-62-7969 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County r than "natural", or Items 23a or 28a-f shov the Madical Examiner must be notified at 1 X Yes 2 No Hagerstown Maryland Washington Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 USA 213 Devonshire Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 1 ☐ Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify. δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 h Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than state hospital dietary permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 Is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joyce Lorraine Franko Charles Minnich ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 213 Devonshire Road, Hagerstown, Maryland 21740 Wayne D. Wilhide - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 Cremation 3 Removal from State 4/18/08 Hagerstown, Maryland Cedar Lawn Mem.Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME E.Wilson Blvd., Hagerstown, Md. 21740 prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final 3 mont Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 2 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 100 director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☑ No 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? After 1 ☐Natural 5 Pending investigation 1 TYes 2 No after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hor To the Function (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 Medical Compre Majerstown Ma Clormack 5H-6 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4-21-2008 **Physician** Paul Richard Wisner 10:26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10-28-1926 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min 81 220-18-2291 MD Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Marked other than account. 1 XYes 2 ☐ No Director MD Frederick Frederick 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 227 Dill Avenue 21701 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 ☐ Married 1XIYes 2 □ No Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give WWII Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Lineman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franklin Hill Wisner Ida Caroline Staub 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PR Prudence Owen 105 E. Patrick St. Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cem. 4 ☐ Donation 5 ☐ Other (Specify) 4-24-2008 Frederick, MD 22. Name and Address of Facility Keeney & Basford P.A.F.H. of Funeral Service Licensee 106 East Church St. Frederick, MD 21701 MO0255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician disease or condition resulting in death) /Medical Due to (as a cons. quence of) Examiner pertensio Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Der and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the ! as IF FEMALE: for use 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 LUNG 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

n 24 hours after death.

Ie Funeral Director: Afte fun by the fun within 24 ho

To the Fune

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> State Registrar

29a, Certifier

(Check only

Medical

and manner stated.

29c. License number

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D 36610

4-23-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Edward F. Fisher M.D. 56 T.J. Drive Frederick, Maryland 21701

31. Date filed (Month, Day, Year) APR 29

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Acord 645 AM Doloros April 26 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner galtimore Harbor Hospital N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Pennsylvania Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 K F 79 Director 140-24-4965 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notlfied at 1 XYes 2 No Baltimore N/A Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with U.S.A. 201 Warren Avenue Apt. 207 21230 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7's Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) Social Security Admin. Elementary/Secondary (0-12) College (1-4or 5+) 12 Processor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura J. Rykaczewski Stanley F. Wojcechowski ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2525 Sidney Avenue, Baltimore, Maryland 21230 Daniel L. Camp 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 104-29-08 Crownsville VA Cem. Crownsville, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition perforated duodenal ulcer **Physician** disease or condition resulting in death) Week /Medical Due to (or as a consequence of): Examiner WOOK Rehal Failure Sequentially list conditions, if any, leading to influented cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner month. Malnutriti on and/ he law requires that the death certificate be execu Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an p ge 2 st autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 201No 2 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? **₩**Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES OOI APril 26,2008 M.D.

State

Michelle K 31. Date filed (Month, Day, Year) 3001 S. Hanover

32. Relistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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Registrar
DHMH 17 Rev 1/2001

12

Baltimore, MD

21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene A Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 24, 7:05 P 2008 April Edward K. Albretsen 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Potomac Valley Nursing & Wellness Center Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 ☑ M 2 ☐ F January 11, 1922 143-14-9814 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√ Yes 2 No Maryland Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 United States 602 Northcliffe Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bank Vice President 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Walters Albert Albretsen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 602 Northcliffe Drive Rockville, Maryland 20850 Nancy Allmang/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery-Crownsville April 29, 2008 Crownsville Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Sep M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumania Due to (of as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of)

Physician /Medical Examiner

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certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria The law requires that the death certificate be

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Certification:

Medical

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Physician

/Medical

10a. State

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or item any injury or other traumatic event the ansister.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Hospitel or Attending Physicien:

death.

the Medical Examiner hast be notified at

Director

Funeral

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Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

26. Place of Death (Check only one)

23d. Date of delivery Month Day Year

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ₩ No

25. Was case referred to medical examiner 1 ☐ Yes 2 2 No 27. Manner of Death

1 Natural

2 Accident

(Check only one)

3 Suicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of

10062435

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Type. Printle & Rockuille, M9
SAYED EISATTAD GAIS Medic Cale B. Rockuille, M9

31. Date filed (Month, Day, Year) APR 3 0 2008

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Martha Lee Brady Anthony 0235 April 22, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Social Security Number 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X F 415-50-7628 March 15,1929 Tennessee Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 7 Greyswood Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2X No Specify. Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Technical Editor Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Lee Brady 2 Edith Rutherford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. Anthony/Husband 7 Greyswood Court, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Funeral Choices of Chantilly Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/28/2008 Chantilly, Virginia 22. Name and Address of Facility Funeral Choices of Chantilly 21. Six ture of Far eral Service Licensee M00968 14522L Lee Road, Chantilly, Virginia 20151 in Line 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Septicemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Multiorgan Failure, Ileus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Maunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No Disseminated Intravascular Coagulation 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ဥ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 attending p for use as SS þ deta Division or Vital Records, has e 2 certificate After Il Director: / within 24 hours aft

To the Funeral Di

completely filled in the Hospital

with the Maryland

28a-f show Items 23a or 28a-f showner must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
sant: If item 27 Is marked other than "natural", or Items 23.
ury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

State

Medical

29a. Certifier

29b. Signature and title of certifier

Machan their

APR 3 0 2008 32. Regularar's Signature MADHAVI HUBBY MEDICAL CENTER 31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0062562

29d. Date signed (Month, Day, Year)

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Funeral Director			M 2□F 55	Yrs.	Months Days	Hours Min.	(Month, Day, 03/26	Year) 5/1953 N	Country)
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or 28	Director	10e. Street and Number			10f. Zip-Code		10	g. Citizen of What	Country?
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yland buld be file Mental Hy arked oth	To Be	Billy Barker, Sr	•			BettyJo	Seacey		
mark	1	19a. Informant's Name/Relationship (Ty	pa. Print)	19b. Mailir	ng Address (Street a	nd Numbar or R	ural Routa Number	City or Town, Stat	e, Zip Code)
Mar d 2 sh tth and tth and 27 Is m		Billy Barker, Jr.,	Brother	800	7 Dalesfo	rd Road	Parkvill	e, MD 212	234
Hear Hear term		20a. Method of Disposition		lace of Dispo	sition (Name of		Date	20c. Location - City	or Town, State
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68/ rtificate ng phy e as th	Jed							1	
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at the datache	, h	9 🗆 Unknown	9 Unknown						
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Inding and a standard	aţio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Workin, Day Year)	ii jai y		Yes 2 □ No			
DIVISION OF VITAL RECORDS, or Attending Physician: The law requires tafer cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be	iji	3 Suicide 6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Town		or Rural Route Number,
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DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	Sal	29a. Certifier 1 Certifying Phy (check only 2 Medical Exam	vsician: To the best of my knowlinar: On the basis of examina	wledge, deat	h occurred at the time time time time to the time of time of time of the time of time	ne, date and plac pinion, death occ	e, and due to the courred at the time.	cause(s) and manne date and place, and	er as stated. If due to the cause(s)
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Vith Com	Š	29b. Signature and title of certifier			29c. License		2	9d. Date signed (N	
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7		30. Name and address of person who		n 23a) (Type	Print)			K- Ot D-111	MD 04007
U.			MMARAJU			600	North Wo	ire St, Balti	more, MD, 21287
	ate	31. Date filed (Month, Day, Year) APR 3 0 2	32. Registrar's Signa	ture	Carte				
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Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) -20-08 **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** auton Harbor 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
QC Yrs. 8. Date of Birth (Month, Day, 6. Sex Funeral 1 M 2 €F Nicarolina 219-07-449° Usual Residence of Decedent Director 10d, Inside City Limits 10a State 10b. County 10c. City, Town or Location nem 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, the Medical Evantinat must be rediffed at 1 ☐ Yes 2 ☐ No 1timore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1300 S. 220 USA 2000 AUENU 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes a No If Yes, Give Year or Dates: 1 Yes 25 No Baltimore, Maryland 21215-0036 Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other then "r College (1-4or 5+) MEDICA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NKNOWN Dance 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Co. 49508 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n eny injury or other treun 2012 Place of Disposition (Name of Ve G13-Anchorage Alaska 20c. Location - Clus Tolin, State Cousin ATTICIA WILLIAM 20a Method of Disposition 124/2008 Baltinon, MD 1 Burial 2 ☐ Cremation 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee reene temeral Service au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NearT Direase atherosclewic Pnysician for 111 vs /Medical Due to (or as a Geros deposis **Examiner** A PANEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). burial-transit Due to (or as a consequence of): CER P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dementia Completed alris Libullation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has Subdural homotoma S/p Craniotomy 1 Yes 2 No 25. Was case referred to medical examiner?

1 X Yes 2 X Ho the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: Injury 1 Natural 2 Accident 5 Pending investigation Subject fell out of bed. 07/27/2005 1 ☐ Yes 2 XNo Unknown M Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 22 S. Athol Ave. determined 4 | Homicide Nursing Home Baltimore, MD 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 20 01/23/2008 male 20011150 I who on O and address of person who completed cause of death (Item 23a) (Type, Print) 441 S, ELLWOOD AVE BALTIMORE, MD MELITO SORRES M. D. Registrar's Sig State Registrar

			State of Maryland / Department /	artment of Health and M rtificate of Death	ental Hygiene Reg. No	2008	4009
6	Physicia		Decedent's Name (First, Middle, Last)		2. Date of Death Month April 14,		3. Time of Death
•	Physicia /Medic	al	Joyce Barnes 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		. County of Death	4:35 PM M
)	Examin	er	Southern Maryland Hospital	Clinton	P	rince Ge	orge's
	Funeral Director		5. Social Security Number 5. 9-82-0551 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth June 22, 196	9. Birthr	place (State or Foreign Tington DC
	pu. »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ocation		1	10d. Inside City Limits
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3, Ma	l and 2 lealth im 27 I		James Barnes Jr./Brother 1506 20a. Method of Disposition 20b. Place of Disp	Danwood Lane, Bowi	Date 20c. L	ocation - City or T	own, State
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Baltimore,	permit. F Departme Importar any Injur		21. Signature of Fuheral Service Lipensee 2	22. Name and Address of Facility Rob 661 Good Hope RD S			
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filed in by the funeral director,	edical C	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, decomposition on the property of the pro	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	To the To the compl	Me	29b. Signature and title of confiler	29c. License number		Date signed (Mont	h, Day, Year)
			30_Name and address of person who completed cause of death (Item 23a) (Type	Se 454		124)	2100
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	St Regist	ate trar	31. Date filed (Month Day, Year) APR 3 0 2008 32. Fegistrar's Signature	Codi			

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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ld be ental ked c	To Be	Edwin Jay Beller	. Sr.				Sat	rah Virgi	nia Ma	rtin	
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of Herm Item		20a. Method of Disposition			lace of Dispo	osition (Name of matory or other place			20c. Location		
Page nent int: If		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate		n Ćremato		30/08	Alexan	dria,	Virginia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee	0	2:	2. Name and Addre	ss of Facility		4739 I	Baltin	nore Ave.
8 3 1 8 8		A Constan	ee Mai	reh	G	asch's Fu	neral Ho	me, P.A.	Hyatts	sville	e, MD 20781
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause on eac	h line.			-	12			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	aAther	osel	evoti	c Cardi	ovascu	law He	aut D	isea	Onset and Death
/Medical Examiner	Ш	Immediate Cause (Final disease or condition resulting in death) a. Atherosclevotic Cardiovascular Heart Pisease Due to (or as a consequence of):									
	e.										
ted nsit		Cause (Disease or injury									
be executed sician and burial-transit	Examin	that initiated events c									
e be (sicial	ल	d									
ifficat g phy as the	edi						-				
h cert	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			75-4:			23d. Da	ate of delive	∍ry
deat e affe	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2∏Feta nt at time of d		」Ectopic pregnancy ☐ Other <i>(specify)</i>	/		М	onth	Day Year
at the by th tache	Physician/Medic	9 ☐ Unknown				_					
w requires that the death certificate been signed by the attending physhould be detached for use as the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									he cause of death?
requir								1 □ Ye	es 2 No	3 ☐ Prob	pably 4 nknown
law as b	Completed							24a. Was a autops		Were auto	psy findings available mpletion of cause of
: The	ပ္ပ							perform	ned? 2 No	death?	2 No
ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hoopital:			LOUI.		ath (Check only on	e)		
Phys this al dir	၉	Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp			nt 3□ DOA Oth	4 Li Nursing F	forme 5 Reside			y)
dlng J. After funer	ion	1 Natural 5 ☐ Pending		Day Year)	28b. Time o Injury	Wor	yat k? Yes 2∐No	28d. Describe ho	w injury occu	rred	
death death ctor: y the	icat	2 Accident investigat 3 Suicide 6 Could not	be 280 Place of	iniury - At ho	ome, farm, sti	reet, factory, office	165 2 110	28f Location (St	reet and Num	her ar Rura	al Route Number,
after Dire	Certification:	4 ☐ Homicide determine	building	, etc. (Specif	y)			City or Town		Dei oi ituie	Triodie (Vanisci,
splta nours neral filled		29a. Certifier 1 Certifying	Physician: To the be	est of my kno	wledge, deat	h occurred at the tir	me, date and plac	e, and due to the c	ause(s) and m	nanner as s	tated.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Ex	aminer: On the bas and manne	is of examina r stated.	tion and/or in	nvestigation, in my o	ppinion, death occ	urred at the time, d	ate and place	, and due to	the cause(s)
To the To the Comp	ž	29b. Signature and title of certifier		A		29c. Licens	e number	2	9d. Date sign	ed (Month,	Day, Year)
/		Harodo	1/2/2	X 3	0	H	00559	27	Apri	129	2008
15		30. Name and address of person wh	o completed cause	of death (Item	23a) (Type,	Print)	0-559 e Cla	1	11	1	
10			vestor 3	istrar's Stona	OSPITE	al Vien	e va	verly	Mary	(ano	<u> </u>
Sta Registi		APR 3 0 200	8 32. Heg	listrar's Stona	A COM	V	•	01			
ricgisti	-41	****			- 5						

08-03207 Rvan Blake Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hyg 1- For State Registrar Certificate of Death		g. No. 200	8 1401			
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death 2230 hrs			
wedical Examiner	Ryan G. Blake 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	April 25, 20	4c. County of Deat				
	University Hospital Baltimore		N/	/A			
Funeral		8. Date of Birth	h(MM/DD/YYYY) 9. Bi Forei				
Director	215-19-6293 1X M 2 F 32 Yrs. Months Days Hours Min.	05/12	o ^{untry)} Maryland				
, k	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits				
ow an				1 Yes 2 No			
rylanc tane	Maryland Anne Arundel Pasadena 106. Street and Number 107. Zip Code	10	g. Citizen of What Cou				
he Ma ined :	8406 Alvin Road 21122		U.S.A.				
or death with the Maryland or items 23a or 28a-f sh Emust be notified at once Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec		14. Race - Ame	rican Indian, Black,			
or iter	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	White, etc.				
s after rral", prince	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo	ri, dono	Specify: W	nite			
5-0036 ed within 72 hour other matter of the Medical Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		Utility	industry			
D36 thin 7 than than than mple	12 N/A Field Engineer		Consulting	g Firm			
5-0 Led wi Hygier I other Cor		irst, Middle, M					
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ite event, the Medica	George S. Blake Gail 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		D	White			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. State: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	George S. Blake (Father) 8406 Alvin Road Pasade		•				
e, N I and 2 Health item 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Class	20c. Location - City of				
nor Pages ent of nt: If	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Glen Haven Mem. Pk. 04/3	n /ns	Clen Burn	ie, Maryland			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee 22. Name and Address of Facility			ie, Haryrand			
	13204 Mountain Road Pasadena, Maryland						
Physician /Medical	23a. Papt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r failure. List only one cause on each line.	espiratory arre	est, shock, or heart	Approximate Interval Between Onset and			
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Cocaine intoxication Due to (or as a consequence of):			Death			
	Sequentially list conditions, b						
iner	if any, leading to immediate Due to (or as a consequence of):			vo.			
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	·····		+			
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\$0, te be execut ysician and burial - tra	X UNPENDED AMENDED 4.27,28a-f, perME,8879 5/29/08 TT						
876 iffcate ig phy is the t	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 1 1 1 1 1 1 1 1	cv	23d. Date of delive Month	ry Day Year			
th cert trendir r use a	past 12 months? 4 Pregnant at time of death 5 Other (Specify)						
O.O. Box 6876 that the death certificat need by the attending phetached for use as the by Physician/N	Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Tago Did to	bacco use contribute t	o the course of death?			
	contributing to death but not resulting in the underlying cause given in Part I.			obably 4 Unknown			
Records, P.C The law requires that froate has been signed it, page 2 should be deta		24a. Was a		autopsy findings available			
e law re law re e has t		autops	med? death?				
Vital Rec ysician: The I his certificate b director, page	25. Was case referred to medical 26.Place of Death (Check or	1 Yes 2	2 No 1 🗸	Yes 2 No			
Vital tysician this certi director	examiner?	,	Residence 6 Oth	er:			
ing Ph ing Ph After t uneral	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2	8d. Describe h	now injury occurred				
sion ttendideath. ctor: y the f	Pending 2 Accident Investigation Fnd 4/24/2008 unk 1 Yes 2 x No	unk					
Division of Vital Records, pital or Attending Physician: The law require ours after death. reral Director: After this certificate has been si filled in by the funeral director, page 2 should be Certification: To Be Completed	3 Suicide 6 X Could not be determined (Specify) house	8f. Location (S	Street and Number or F tate) Veland St. Ba	Rural Route Number, City			
Tospita Tospita Tospita Tospita Tospita Tospita	29a. Certifier						
To the Hospita within 24 hours To the Funeral completely fille	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the surface and place, and death occurred at the surface and place and death occurred at the surface and death occurred at the surf						
Me.	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	lonth, Day, Year)			
	Mayorie The Chale O.C.M.E.		April 26, 2008				
D	30. Name and address of person who completed cause of death (Item 23a)	1007					
	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature	120 1					
State Registrar							

				For State	State of	Marylan		rtment e			and M	ental Hy		0000	11010
				Registrar 1. Decedent's Name (First, Middle,	(ast)		061	incate	OI L	Julin		2. Date of De	Reg. No.	11116	3. Time of Death
		Physicia	an									Month	Day	Year	
		/Medic		Bruce Nelson 4a. Facility Name (If not institution,		nber)		4b. City, To	wn. or	Location o	of Death	April	25,	2008 ounty of Death	9:40 P [™]
U	,	Examin	er	Stella Maris	,					nium				Baltim	
		Funeral				7. Age (In yrs. I	ast birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Bi	rth	9. Birth	place (State or Foreign
		Director		142-16-4429	1 <u>⊠</u> M 2□ F	87	Yrs.	Months [Days	Hours	Min.	(Month, D Sep. 1'	7, 192		ssouri
i	g	>		Usual Residence of Decedent		10- 07	- T1-	- 4:				1			10d. Inside City Limits
	aryla	shov	卢	10a. State 10b. County		Toc. City	y, Town or Lo	cation							1 ☐ Yes 2 ☑ No
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	vith t	De n		10e. Street and Number				10f. Zip C						en of What Cou	ntry?
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	rer de	item	Ë	 Marital Status Never Married 2 Married 	Armed For	ces?		f Yes, specify	/ Cubar	n, Mexican	n, Puerto	ecify Yes or N Rican, etc.)	0- 1-	Black, White	
ė.)36 Irs af	P. E	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	е	1	l∐Yes 2¶s	₽No	Specify:			8	Specify:	ite
p.m.	6 2	atura	ted	15. Decedent's			16a. Deced	ient's Usual (Occupa	ation			16b. Kind	d of Business/li	
0	215 File	Med "n	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	-4or 5+)	(Give life. L	kind of work o OO NOT use	done di retired)	luring mos:)	t of workii	ng			
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ο ₁ .	and be file	al Hy	Be (17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	(First, Middle	e, Maiden S	urname)	
80	Maryland 21215-0036 d 2 should be filed within 72 hours aft	Ment arked atic e	٥	Bruce J. Brown						Ur	sula	M. Wi	ld		
2008	lar 2 sho	is m		19a. Informant's Name/Relationship										Town, State, Z	p Code)
	and and	ealth n 27 ner tr		Jeanne Bayer / N	Niece							oppa, I			
25	altimore,	Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1X Burial 2 Cremation / 3	□ Removal from S	State 20b. P	lace of Dispo emetery, cren	sition (Name natory or othe	of er place	e)	D	ate	20c. Loca	ation - City or T	own, State
7	E a	tant: jury		4 □ Dogation 5 □ Other (Spe			Air M							Air, M	aryland
April 	Balti permit.	Impor any in once.		21. Signature of Funeral Service Lie	certisee / (1)	/	∠ Mc	. Name and a	Addres Fur	s of Facilit neral	y Home	e, P.A			
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				23a. Frt1. Enter the disease, or co shock, or heart failure. List or	omplications that cally one cause on ea	aused the death ach line.	n. Do not ent	er the mode of	of dying	g, such as	cardiac c	or respiratory	arrest,		Approximate Interval Between Onset and Death
		ysician		Immediate Cause (Final disease or condition resulting in death)	_a. Colo	n Cance	r								Onset and Boats
		Medical kaminer		resulting in death)	Due to (or as a consequ	uence of):								
			<u>.</u>	Sequentially list conditions,	b. Due to (or as a consequ									
	ted	ısit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	Due to (or as a consequ	derice or).								
V	y ecu	and al-trai	xar	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):								
	8760, cate be executed	physician and the burial-transit													
	687 tifficate	phy:	Physician/Medical		a										
	Cert	nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo								23	3d. Date of deli	verv
1	death G	d for	cial	in the pest 12 months?	4 ☐ Pregn	irth 2□Fetal ant at time of d		Ectopic pred Other (spec		<u>'</u>				Month	Day Year
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	s that	ned le det	by P	Part II. Other significant condition	s contributing to de	ath but not resu	ulting in the ur	nderlying cau	ise give	en in Part I	,	23e. Did	tobacco us	e contribute to	the cause of death?
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g	BW re	s be	Completed									24a. Wa		24b. Were au	opsy findings available
Brown	The L	ite ha	E O									perl	opsy ormed?	death?	ompletion of cause of 2 No
Ä.	<u>=</u>	rtifice tor. p	Be C	25. Was case referred to medical						26. Place	of Death	1 □ Yes (Check only		1 🗆 163	2 🗆 140
ce	f <	nis ce direc		examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ I	npatient 2 🗆	ER/Outpatier	nt 3 □ DOA	Othe	er: 4 □ Ni	ursing Ho	me 5 ☐ Res	sidence 6	Other (Spec	ify) HOSPICE
Bruce	C F	fter th	٦	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of	of Injury h, Day, Year)	28b. Time of Injury	280	. Injury Work	/ at		28d. Describe			
μ.	ibus	ath.	atic	2 Accident investigation	tion	.,, =,, ,	,,	M		Yes 2□	No				
	Division of Vital Records, i or Attending Physician: The law requires to	recto	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad Zoe. Place	of Injury - At ho	ome, farm, stre	eet, factory, o	office		:		(Street and wn, State)	Number or Ru	rai Route Number,
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	the	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	ledi	one)	and man										
	²	To Cor	Σ	29b. Signature and title of certifier	1~ 1	1	1	29c. l	License	number	W.		29d. Date	signed (Month	, Day, Year)
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	7			30. Name an address of person w		1		ŕ							
	0	i		DR. ERNESTINE W	RIGHT 2	300 DUL	ANEY V	ALT.EY	RD.	TT	TTMON	IM. MD	21093		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4:13 P Sondra L. Brunner April 22, 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Days Hours Months 1 ☐ M 2 ☑ F Yrs 66 201-32-1890 June 15,1941 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 Jasmine Court United States 20853 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 ☑ No Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Technology 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley Zeveney Sarah Grant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jasmine Court, Rockville, Maryland 20853 Ronald G. Brunner/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Apr. 25, 2008 Bethesda, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service License Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 M01498 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

Completed by

Be

P

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

that the death certificate be executed e attending physician and d for use as the burial-trans been signed by the should be detached

Box 68760,

P.O.

Division or Vital Records,

or Attending Physician:

Physician/Medical Examiner

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Completed

Be

Certification: To

Medical

(Check only one)

29b. Signature and title of certifier

cate has been a page 2 should certificate director, this (After thi funeral within 24 hours after upgar...

To the Funeral Director: Af

To the Hospital

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🙀 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

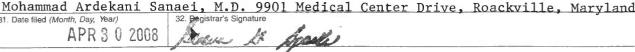
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

20850

State Registrar 31. Date filed (Month, Day, Year) APR 3 0 2008



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day April 23, 2008 **Physician** 2:00 P Violet Gertrude Buhler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Liberty Assisted Living 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 😾 F 93 Yrs. 086-01-0193 Director Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinating roust be notified at 1 ☐ Yes 2 ☑ No Director Potomac Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 12205 Meadow Creek Court 20854 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event. The Industrial of Industrial of Industrial of Industrial Indus 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Specify: þ 3 ₩ Widowed 4 Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Marie Schmidt Charles Ransom Baxter ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12205 Meadow Creek Court, Potomac, Maryland 20854 Warren Buhler/ Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place 20a Method of Disposition April 25, 2008 Bethesda, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee M01498 Logs Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Dysphagia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Vascular Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Seizure Disorder Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 🔽 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 □ Nursing Home 5 □ Residence 6 ☑ Other (Specify)Facility 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tile of cert April 24, 2008 D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Avenue #305, Bethesda, Maryland 20814 Susan J. Miller, M.D. 32. Registrar's Signature 31. Date filed (Month, APR 3 0 2008 State Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARBOR HOSPITAL TIMOR ISAL N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 04/30/1954 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 10X M 2□ F Maryland 213 64 0381 53 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Anne Arundel 1 □Yes 2 X No Baltimore Marvland Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be 138 W. Meadow Road U.S.A. 21225 Funeral 14. Race - Americen Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) MD Paper Box Company event, the Forklift Operator 12th 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) Be Charles Bealer Jr. ပ Nellie Schultz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Bealer / Brother 2082 W. Sassafras Street Selinsgrove, PA 17870 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park | 04/29/2008 | Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UNG ANC **Physician** /Medical Due to (or as a consequence of): Examiner TRUCTEUE PULMONARY DISEASE ING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last on GESTIVE Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria INOM! Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform ormed. 2 🗹 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Hospital: 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number RES ØØØ 29b. Signature and title of certifier BABAK 29d. Date signed (Month, Day, Year) Mi). REDATAT, 3001 SHANOVER ST. BALTEMORE, MI). 21225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RABAK BEDATAT M.D

Registrar

State

31. Date filed (Month, Day, Year)

32. pgistrar's Signature

			1 - For State Registrar	State of	Maryland		artment of H tificate of L		nd Men		ene () ()	8	14016
			1. Decedent's Name (First, Middle,				0			Date of Death Month		Year .	3. Time of Death
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			303 - 16th Ave	nue			Baltimo				Anne		
	Funeral			6. Sex 7 1X M 2 ☐ F	. Age (In yrs. I		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. E Min. (Date of Birth Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign try)
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	death with the Maryland ms 23a or 28e-f show r must be rediffed at	Funeral	11. Marital Status	12. Was Deced	en! Ever in U.	S. 13. 1	Was Decedent of Hi 1 Yes, specify Cuba		in? (Specify	Yes or No-	14. Race		an Indian,
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5	filed within 72 hours efter Hygiene. sther than "natural", or ite ent, the Medical Expanition	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occupa	ation	of working		6b. Kind of Bus	iness/Ind	lustry
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<u>8</u>	should be nd Mentel marked c	2	Wal	ter Brager	•				phie J				
0	and and is m		19a. Informant's Name/Relationsh				ng Address (Street						
2 *`	sermit. Pages 1 end 2 should be filed within 72 hours eller death with the Marylan Depertment of Health and Mentel Hygiens. Important! for items 23a or 28e-1 show mortant! item 27 is marked other than "natural!, or items 23a or 28e-1 show any injury or other traumatic event, the Midles! Examinar mail to indiffed at another.		Mark Brager /	Son	Jan. 3		- 16th Av	renue	Ba1 Date		e, Maryl		
מבים	P of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from S	tate C	emetery, crei	sition (Name of natory or other plac				20c. Location · C	•	
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0	v requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 ☐ Fetal	death 3	Ectopic pregn <i>a</i> ncy Other (specify)				23d. Date Mon		Day Year
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5	ding Physician: The n. After this certificate h tuneral director, page	T.	1 ☐ Yes 2 ☐ No 27. Manner of Death			ER/Outpatier 28b. Time o	IL 3 DOA	4 Nul			ince 6 Othe		v)
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2	effer Dire	ertification:	4 Homicide determine	building	g, etc. (Specify	v)	, , , , , , , , , , , , , , , , , , , ,			City or Town	, State)		
	spita lours nerai	2	29a. Certifier Certifying	Physician: To the t	est of my kno	wledge, deat	h occurred at the tin	ne, date and	d place, and	due to the ca	ause(s) and mar	ner as st	tated.
	To the Hospital or Attending Phys within 24 hours eiter death. To the Funeral Director: Atter this completely filled in by the funeral dir	edici	(Check only 2 Medical E	xaminer: On the bas and manne	sis of examinat	tion and/or in	vestigation, in my o	pinion, deat	th occurred a	t the time, da	ate and place, a	nd due to	the cause(s)
	To th Withir To th Domp	Me	29b. Signature and title of certifier	, A A	. `		29c. Licens	e number		2	9d. Date signed	(Month,	Day, Year)
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	141		30. Name and address of person v	no completed cause	of death (Item	n 23a) (Tyge,	Print) USHA	7 Vz	MUL	AKO	1226	,	۵
	. / ,	18	4710 PENNIN	GTON	AVE	B	ALTIM	URR,	MI), 2,	1226		
	Sta	ite	31. Date filed (Month, Day, Year)		gistrar's Signa	luro 8	OF.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Brown 08 am **Physician** 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Haryland timor University of Medical If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1**¥** M 2□ F 53 217 62 7984 Maryland 10/23/1954 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or here traumatic event, the Medical Examiner must be notified at ury or or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1y Yes 2 No Baltimore Director Maryland N/A 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21226 U.S.A. 4102 Curtis Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+) Welder Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Brown Betty Henry မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4102 Curtis Avenue Baltimore, Maryland 21226 Patricia McGuiness / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/01/2008 | Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 21. Signatur**a** o**zbu**neral S 22. Name and Address of Facility a Licensee Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month **Physician** neumonic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-transi and Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exwinting 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 TYes 2 V No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an thermia autopsy performed' 2000 1 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Flowers 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 51.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 3 0 2008

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth Month **Physician** Pusiciani Bieden Kapp, Henney Kenneth W. Biedenkapp, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** VA Maryland Neath Care System

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 € M 2 □ F Months Hours Min. 155-34-8559 Director 05-22-1945 Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2222 Tollgate Circle 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 212 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Paver Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myoun to Kenneth W. Biedenkapp, Sr. Helen Reillv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Malone (Wife) 2222 Tollgate Cir. Bel Air, MD 21015 Department of Health Important: If Item 27 any Injury or other trong. 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 04-25-2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Li Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** arcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician end burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnency in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ omatosis.DiabetesMel page 2 should Completed 24a. Was an autopsy certificate perform 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? ospital or Attending I hours after death. 1 Natural 5 Pending investigation within 24 hours after deam.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

20c. Location - City or Town, State Baltimore, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 2 **N**No 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) ustodio, M.D., Vamaryland Health Care System, Perry Point, mo 21902

4018

3. Time of Death

8:50 A

9. Birthplace (State or Foreign

NJ

10d. Inside City Limits

1 ☐ Yes 2 🛛 No

2008

County of Death

14. Race - American Indian, Black, White, etc.

White

ecil

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** 1209 PM 04-21-2008 Mark Edward Blakeley /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford UPper Chesapeake Hospital Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min Maryland 54 11-04-1953 212-62-8997 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Edgewood Harford Maryland 10g. Citizen of What Country? 10e. Street and Number USA 21040 106 Laburnum Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No | 08 | 209 PM |e, Maryland 21215-0036 Specify: White Specify. à 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Company Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathryn Altomare Charles Blakeley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edgewood, MD 21040 106 Laburnum Rd Patricia Blakelev (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 04-24-2008 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stroke Physician Acute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) r use as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2□ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Dinpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours af To the Funeral D completely filled in 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cedifier D63420 April 21, 2008 Con 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

L. Kharal

500 upper Chesapeuke Dr, Bel Air IND 21014

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 1016A M 8005 FRANCELIA BENNETT APRIL /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BRIGHTWOOD LUTHERVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02/22/1916 9. Birthplace (State or Foreign Country) NEW YORK 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗹 F 074-12-4848 92 Director Usual Residence of Decedent Manyland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Iteme 23a or 28a-f ehow treumatic avent, the Medical Examiner must be notified at Director 1 Yes 2 No MD BALTIMORE LUTHERVILLE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 BRIGHTWOOD RD. 21093 USA by Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12YRS College (1-4or 5+) OFFICE WORK RADIO STATION ges 1 and 2 should be fill of Heelth and Mental Hy If Item 27 Is marked other other treumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LESLIE J. BENNETT ZETA B. O'LEARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY K. MARTIN (POA) 26 LINCOLN WOODS LN. BUFFALO, N.Y. 14222. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of H ant: If Ite ury or otl Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any injury or once. MT. OLIVET 04/28/2008 4 ☐ Donation 5 ☐ Other (Specify) TONAWANDA, N.Y. 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO
16924 YORK RD MONKTON, MD. SONS CO. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician END STAGE DEMENTIA years /Medical Due to (or as a consequence of): Examiner PARKINSON'S 4eoulo DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sete has been signed by the ettending physicien page 2 should be detached for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 ☐ Yes 2 ☐ No 2 2 No 1 ☐ Yes : After this certifice funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending within 24 hours efter death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 23 2008 Speple MD DO053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 110 SANTIAGO RD SHAKUNNALA GUPTA 9650 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 3 0 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene UUS Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Apr 25, 2008 9:00 P M George Beaver /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Mt. Airy Pleasant View Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1**X** M 2□F 81 215-32-1387 Director Mar 10, 1927 Usual Residence of Decedent death with the Maryland 10c. Cify, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Clarksville Director MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or edical Examiner must be U.S.A. 21029 6420 Warm Sunshine Path Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) **Property Management Building Maintenance** unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Slorp Paul Edgar Beaver 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6420 Warm Sunshine Path Clarksville, MD 21029 Betty L. Beaver - spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 Burial 2 Cremation Department or Important: If any Injury or Apr 29, 2008 Gleneig, MD 4 ☐ Denation 5 ☐ Other (Specify) **Providence Cemetery** 21. Signature of Funeral Service Licen 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MOEX 35 Approximate Interval Between Onset and Death , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. art1. Enter the dise Immediate Cause (Final disease or condition resulting in death) **Physician** BRONCHOPNEURONIA weak /Medical Due to (or as a consequence of): Examiner SENITE DEMBNIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine BARKINSONISM burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No DEPRESSION 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (10 28. D30469

Registrar

31. Date filed (Month, Day, Year)



30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 5 0 , COLUMB: A 100 PARKWAY #

308,

columbia.

Mo. 21645-2377

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:16 AM Claude Randolph Berry Apr 24, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Carroll County General Hospital** Carroll Westminster If Under 24 Hrs. 8. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Hours Months Days 219-38-2681 67 Director Apr 11, 1941 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes Director MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 2301 Hampstead-Mexico Rd. 21157 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status within 72 hours after 1 Never Married 2 Married 2 No 1 ☐ Yes Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Inventory Manager** Warehouse 12 should be filed w h and Mental Hygiei 7 Is marked other th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Joseph Berry Ruby Virginia Dean မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Keith R. Berry 8833 Round House Circle Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Apr 28, 2008 Ellicott City, Maryland 4 □ Domation 5 □ Other (Specify) Good Shepherd Cemetery 21. Synatur of Fundal Service Licer 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Mais 36 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ney mon Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificata be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by tha attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Disease 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 20 No 1□ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Injury at Work? Medical Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 W Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🗹 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier laver Ill

State Registrar

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31. Date filed (Month, Day, Year) APR 3 0

Naveed



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Itemstate per Maryland / Department of Health and Mental Hygiene fin g882,08/28/08dhb (Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** tone 2008 25 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Ellicott City** Howard Ellicott City Health & Rehab Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 09/14/1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F MD 78 218-26-2033 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No **Ellicott City** Director MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 8900 Frederick Rd. U.S.A. 2 should be filed within 72 hours after death and Mental Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Lionel Burgess** Lenna Baker 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2813 Still Leaf Lane Ellicott City, MD 21042 Stephen Burgess 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Apr 29, 2008 Baltimore, MD 4 □ Donation **Bayview Crematory** anaty of Funeral Service Liousee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MOOS Part1. Enter the dispess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician isease or condition resulting in death) /Medical Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit The law requires that the death certificate be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4⊡Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation r death. 1 ☐ Yes 2 ☐ No within 24 hours after deaf To the Funeral Director 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year)
April 25 200 8 29b. Signature and title of certifier 29c. License number D32641 Back River Wick Road Baltime 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-10 Salvanulta

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Linda Bennett 2008 04 26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 5. Social Security Number 6.5 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 🛛 F 218-50-7119 7-2-1952 Director 55 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Co. Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 7946 Kavanagh Road USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 N/A Merry Maid Housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ambrose Stepek Concetta Vienna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7946 Kavanagh Road John Bennett - Husband Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Holly Hill Cemetery 4-30-08| Middle River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SCV RAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause University of that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4€ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ∐Yes After this certificate 2 No 200 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Injury 1 X Natural within 24 hours after upon To the Funeral Director: After To the Funeral Director: After To the Funeral Director of the Funera 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ax 10 pens

Registrar

State

Johns Hopkins Boyview Medical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 3 0 2008

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of N	naryiano i		tificate of i		nentai Hy	giene Reg. No.	000	8		025
	Physici	an	1. Decedent's Name (First, Mid	die, Last)					2. Date of De Month	eath Day	y Ye	ar	3. Time o	
Į.	/Medi	cal	Samuel Paul						April :	26,	2008		1:30	P M
	Examir	ner	4a. Facility Name (If not institut Baltimore Rehab	-		Care		Location of Death		4c.	County of D	eath		
	Funeral Director		5. Social Security Number 212–48–1839 Usual Residence of Decedent		Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March 2	ay, Year)	947 C	Birthplac Country	ce (State v) noma	or Foreign
	/land ow at		10a. State 10b. Coun	ty	10c. City, T	own or Lo	cation					10d	f. Inside C	ity Limits
	a-f sh	ctor	MD		I F	Balti	more						XXIYes	2 □ No
	ith the	Dire	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What	,	y?	
	s 23a nust t	ral	218 N. Charles			10.1		201			U.S.			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Manital Status XX Never Married 2 Married 3 Widowed 4 Divorce	ed If Yes, Give Year or Dates	Vietna	m	Was Decedent of H f Yes, specify Cuba I ☐ Yes	Specify:	Pican, etc.)	ļ		/hite, etc Whit	te	
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	al Hyginal Action	Be	17. Father's Name (First, Middl	•				18. Mother's Nam	e (First, Middle	, Maiden	Surname)			
ya	Meni Meni Meni Meni Meni Meni Meni Meni	٩	Philip Lloyd						Flore					
Maryland	d 2 sho th and t7 is ma traum		19a. Informant's Name/Relation Robert Clark		I .		ig Address (Street) 1. Charle					e, Zip C	Gode)	
	es 1 and 2 of Health fitem 27 i		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of	-	Date		ocation - City	or Towr	n, State	
mo	Page nent o int: If iry or		AX Burial 2 □ Cremation 4 □ Donation 5 □ Other		e Garr	rison rans	Forest Cemetery	May 5	5, 2008	Ow:	ings M	i11s	s, MI)
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Puperat Solvice	te Licensee		22	Name and Address.	ss of Facility EC				~		7
	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	a. ASPI	RATI	DN	er the mode of dyin			arrest,		A Ir C	Approxima nterval Be Onset and	te tween Death
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O. Box	ath cer titendin or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 ☐ Fetal de at time of deati	eath 3	Ectopic pregnancy Other (specify)	1			23d. Date of Month		ay	Year
<u>α</u>	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant condi	tions contributing to death	but not resultin	ng in the ui	nderlying cause giv	en in Part I.			use contribut □ No 3 □	e to the		death? Unknown
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Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Oth	26. Place of Deal						
o		٦: <u>٦</u>	27. Manner of Death	1 □ Inpa 28a. Date of In	jury 28	Outpatien b. Time of	1 3 DOX	4 Mursing H	ome 5 ☐ Resi 28d. Describe			Specify)		
ion	ath. or: After ne funer	ation	Z L Moddon	stigation	lay Year)	Injury		k? Yes 2 ☐ No						
Division	i or Attend after death Director:	Certification:	3 Suicide 6 Coul 4 Homicide deter	minod Zoe, Flace of I	njury - At home etc. (Specify)	, farm, str	eet, factory, office		28f. Location (City or To	Street an wn, State	nd Number o	r Rural F	Route Nui	mber,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Co	29a. Certifier 1 Certify (Check only one) 2 Medic	ring Physician: To the bes at Examiner: On the basis and manner:	of examination	dge, deatl	n occurred at the tirvestigation, in my o	me, date and place pinion, death occu	, and due to the rred at the time	cause(s) and manne d place, and	r as stat due to th	led. he cause	(s)
	To the To the Comp	Me	29b. Signature and title of certif	fier	VA.	Δ	29c. Licens	e number		29d. Da	te signed (M	onth, Da	ay, Year)	
	, ,		Huma	Ci lan	, Mr	NI.	$\cup DI$	4758		APR	114	29,	200	18
1	141		30. Name and address of person	TAN 3900	Lock	RAV	EN BOUL	EVARD,	BALTIM	ORE	, MD	21	218	-10
	Sta Registr		31. Date filed (Month, Day, Yea APR 3	199	trar's Signature	A	ned							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Month opeland 0300 M **Physician** 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number Examiner CALUMBIA nd Hound COUNT Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. **Funeral** Days 1 ☐ M 2 🕱 228-34-5768 85 JULY 29, 1922 VA Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10h. County 10a. State 28a-f show If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ▼Yes 2 No ELKRIDGE Director MD HOWARD 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 21075 6901 SCARLET OAK DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) Giant Open Air Market Associate permit. Pages 1 and 2 should be filed a Department of Health and Mentat Hygis Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Faulcon Donnell O'Neal ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6901 Scarlet Oak Drive Elkridge, MD Florence C. Wilson/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date unk 20a Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State Chesapeake, VA Roosevelt Mem. Park 4 Donation 5 Other (Specify) Marshall's Funeral Home of MD 22. Name and Address of Facility 21 Signature of Funeral Service Licensee 20746 Suitland, MD Donald R. Gray 4308 Suitland Road 28a. Pant. En r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart rature. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic Immediat Cause inal CALDINACULAN **Physician** disease or resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the 88 attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the a detached f 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 → hknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s autopsy performed? 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

1 Natural 5 Pending

investigation

2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

30. Name and address

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

29b. Signature and title of certifi

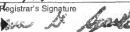
29d. Date signed (Month, Day, Year) 19/320 Ap/ 23, 2008 leds la Colubia, md 21044

5 State Registrar

Medical

MO(/4) HOWALD 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 3 0 2008

of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Year Month Physician APRIL 24 2008 7:27 A KENNETH **ISAAC** COX /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 5. Social Security Number Days **Funeral** Hours 1 X M 2 □ F JAN 16, 1945 63 Director 239-70-4660 Usual Residence of Decedent 10d Inside City Limits the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10a. State 1 X Yes 2 □ No FORESTVILLE MD PRINCE GEORGE'S Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number items 23a or 2 Iner must be no with 1 20747 USA 3421 REGENCY PARKWAY by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 No f Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 "natural", or Specify: If Yes, Give Year or Dates: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. other than " ent, the Mer Elementary/Secondary (0-12) College (1-4or 5+) DC PUBLIC SCHOOLS SCHOOL TEACHER YRS h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SADIE FEREBEE THEODORE COX 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 3421 REGENCY PARKWAY FORESTVILLE, MD MELISSA COX / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedarwood Cemetery 05-03-2008 HERTFORD, NC 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Donald R. Gray 4308 SUITLAND ROAD SUITLAND, MD 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MNOUATEN Immediate Cause (Final n +551 m **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day in the past 12 months? ☐Yes 2☐No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 2□ No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3□ DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation s after death. death. 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I 🛮 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04124/09 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 7503 Surratts Road Clinton, MD Eric McDonald 2. Registrar's Signature 31. Date filed (Month, Day, Year) APR 3 0 2008 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:40 AM CREECH 24 2008 APRIL GERALDINE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S CLINTON BRADFORD OAKS NURSING & REHAB Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Min. 1 ☐ M 2 🔀 Months Days Hours North Carolina 238-40-9532 77 August 6, 1930 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10b. County 10a. State show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 XYes 2 No Director Suitland Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20746 2006 Lakewood Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: ģ **Black** 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Field Representative Census Bureau 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Williams Jerry Gaylord ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2006 Lakewood Street Suitland, MD Alonzo Creech / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State 05-02-2008 Suitland, MD Lincoln Memorial 4 Donation 5 Other (Specify) MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20746 1 4308 SUITLAND ROAD SUITLAND, MD Donald R. Gray 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or light) that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 1 🔲 Inpatient 2 ER/Outpatient 3□ DDA 2 Director: After th 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural
2 Accident (Month, Day Year, 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ourus April 28, 2008 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FORT WASHINGTON, MD 20744 11711 LIVINGSTON ROAD TANNER WILLIAM 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar APR 3 0 2008 Eller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2003 1:46 PM **Physician** Lesta /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 6906 MARKEL Dundalk 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 27 Social Security Number 7. Age (In yrs. last birthday) Year) 925 **Funeral** Country) Months Days Hours Min. 1 M 2□ F 5502 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ns 23a or 28a-f show 1 ✓Yes 2 No Director Baltimore Dundalk MATYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 2 minimatic event, the Medical Examiner must be none. U.S.A 21222 6906 MATKEL Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Strol Elementary/Secondary (0-12) College (1-4or 5+) MillWORK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antoinetta KATAKOWAKIS Cesta Moelo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21222 Ave Dradalk MD davahter 1601 Delvale Becker Anita 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Baltimore, Crematory BAYVIEW 2008 5 ☐ Other (Specify) 4 Donation 21. Signature Funeral Service Licensee 22. Name and Address of Facility Connelly Sollers 7 Home, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 16C /Medical Due to (or as nsequence of) Examiner oronar if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due(to (of as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) I□Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. ð 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performer this certificate 2 🗆 No 1 ☐Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After t (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ertifying Physician: 10 the best of his knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 32. Registrar's Signature

APR 3 n 2008

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registral's signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 **Physician** ROSE R. CERVIN ,26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ę race 2en vursir TOMP 9. Birthplace Country If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) ial Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ ME 218-42-7068 1912 Director 95 Oct. 8, Illinois Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2√2 No be notifled Directo Maryland | Harford Abingdon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 815 Hilltop Avenue 21009 USA Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 🛣 No FYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Jan (nmn) Kortus Rose (nmn) Voldrich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Huber / Daughter 514 Sellrus Court, Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bohemian Nat'l Cem. 5-2-08 Baltimore, Maryland 4 Donation 5 Other (Specify) McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each time. Immediate Cause (Final disesse Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 5 □ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2110 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

been signed by the attending physician The law requires that the Division or Vital Records, has or Attending Physician:

the Maryland

with

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director; After this certificate filled in by the

State

DHMH 17 Rev 1/2001

Medical

4 ☐ Homicide

(Check only

31. Date filed Month.

29b. Signature and title of certifier

Day,

and manner stated

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year 9. Birthplace (State or Foreign Age (In yrs. last birthday 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 216-28-8665 Usual Residence of Decedent 1 □ M 2 X F Director 10d. Inside City Limits Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show digal Examiner must be notified at 1 ☑ Yes 2 ☐ No Director mor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 N If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 ac 3 ☐ Widowed 4 ☑ Divorced or than "nature the Medical E 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 27 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary ပ 19b. Mailing Address (Street and Number or Fural Route Number, City or T. wn, State, Zip Code) Informant's Hame/Relationship (Type. Print) Wiece) permit. Pages 1 and 2 s Department of Health ar important: If Item 27 is any Injury or other trau F100 City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location -20a Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 12008 awn 4 Donation 5 Other (Specify) 22. Name and Address of Ficility Joseph L. Rus 2222 W. North 21. Signatore of Funeral Service Licensee 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition neumonia **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specity) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2**X**No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? EMENTIA 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes after death.

Director: After this certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ D0A Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death 5 Pending Investigation 1 Natural
2 Accident Injury 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specity) 3□ Suicide determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified M WID D35102 Wilselly

Registrar

State

5901 north

32. Registrar's Signature

CHAYLES STreet

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryla State Registrar	•	rtment of H		_	giene Reg. No. 2	008	14032
			Decedent's Name (First, Middle, Last)				2. Date of De Month		Year	3. Time of Death
	Physicia /Medic		Agnes F. Carnabuci				APRIL	27	2008	11:50 AM
E	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death	
4			Union Memorial		Balto					
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>ln yr</i> 1 □ M 2 ☐ F 80	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birthp	**
	Director		220-22-6248 Usual Residence of Decedent	115.			4-23-	1928		Md.
	and w	1		City, Town or Lo	cation					10d. Inside City Limits
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	the 1 28a- notif	Director	Md. Balto. 10e. Street and Number	Perry	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	3a or		9600 H Amberleigh Ln.		2	1128		USA		
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No	14. Ra	ace - Americ	
9	after or Ite		1 Never Married 2 Married 1 Yes 3 No		1 ☐ Yes 🌠 ☐ No	Specify:	Thous, cto.,	Spec		White
93	be filed within 72 hours after death with the Maryland Hygiene. A thygiene do ther than "natural" or items 23a or 28a-f show do ther than "natural" or items 23a or 28a-f show event, the Medical Ex miner must be notified at	d by	3 Widowed 4 □ Divorced Year or Dates:							
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Maryland 21215-0036	be d o	To Be	Edward T. Bacon			Ida Mae	Jones			
<u> </u>	₹ D E E	ř	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rui	ral Route Numb	er, City or Tow	n, State, Zi	p Code)
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altimore,	- I b =			. Place of Dispo	sition (Name of matory or other place	e)	Date	20c. Location	- City or T	own, State
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S	Attend death. ctor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - A	t home farm str		res ZLINO	28f Location	(Street and Nu	mher or Ru	ral Route Number,
Division or	or Attencafter death	Certification:	4 Homicide determined building, etc. (Spe	ecify)	rect, lactory, office			iwn, State)	71001 01 7101	a rosto rumbo.,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, deat	th occurred at the ti	me, date and place	, and due to the	e cause(s) and	manner as	stated.
	24 h e Fur letely	Medical	(Check only 2 Medical Examiner: On the basis of examone) and manner stated.	nination and/or in	nvestigation, in my	opinion, death occu	irred at the time	, date and plac	e, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. Licens		,	29d. Date sig		
			DAMIRA MOHAMMED SIYA	M, MC	AT 2.	43894		APRIL	- J7	2008
7	12		30. Name and address of person who completed cause of death (I	tem 23a) (Type,	Print)	. 11		211	INPE	AM.
	1		30. Name and address of person who completed cause of death (I	Unior	MEMOR	JAL MOSPI	- IML) !	CALITE	~ 1 - 1	,
	Sta Registi		31. Date filed (Month, Day, Year) APR 3 0 2008 32. Gegistrar's Si	gnature	mele					

DHMH 17 Rev 1/2001

	1	State of Maryland / Department of He Registrar State of Maryland / Department of He Registrar	ealth and M	ental Hyg	-	14033
D		Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th Day Year	3. Time of Death
Physiciar /Medica	I .	Concetta Crispino		94	26 2008	3 [7 "
Examine	r	4a. Facility Name (If not institution, give street and number) Ridgeway Manor Nursing Home 4b. City, Town, or C	Location of Death Catonsville		4c. County of Death Baltir	nore
Funeral Director		5. Social Security Number 220-20-9924 6. Sex 1 Months Days 79 Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		olace (State or Foreign htry) MD
riand	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
B Man	1013	MD Baltimore	Catonsville			1 □ Yes 2 No
3a or 26	II Dire	10e. Street and Number 5743 Edmondson Ave.	21228	1	0g. Citizen of What Cour U.S.A	
be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "naturel", or items 23a or 28e-f show event, if a Modical Exercities to the following the mailting at the modified at the modified at the modified at the following the fol		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent of His His Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: White	etc.
hours hours	a by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				ductar
21215-0036 ad within 72 hours aff of than "naturel", or than "naturel", or	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupa (Give kind of work done dilife. DO NOT use retired)	uring most of workii	ng	16b. Kind of Business/In Own He	•
N pos	E	8	maker			
Maryland d 2 should ba file th and Mental Hy th and Mental ch traumatic event	o Re	17. Father's Name (First, Middle, Last) Rocco Alimo	18. Mother's Name		Maiden Sumame) ohine Alasico	
re, Maryla s 1 and 2 should theath and Mer tiem 27 is marke other traumatic		19a. Informant's Name/Relationship (<i>Type, Print</i>) Mr. Arthur Crispino Spouse 19b. Mailing Address (<i>Street al</i> 5741 Edmondson				Code)
0 0		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place Maryland Veterans Cemeter)		ate 1, 2008	20c. Location - City or To Garrison Fore	
Baltime permit. Pag Department Important: I eny injury o	,	2) Sign ture of Vineral Service (Lensey) 22. Name and Address Slack Fun	s of Facility eral Home, P./ Columbia Pike	A. Ellicott City	y, MD 21043	
	cal Examiner	a. He to (or as a consequence of): Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
	Pnysician/medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown			23d. Date of deliv Month	ery Day Year
rdS, P		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.		bacco use contribute to t es 2 □ No 3 □ Prol	
Of Vital Records, Physicien: The law requires t this certificate has been signe ral director, page 2 should ba.	Completed by	Daleter		24a. Was a autops perform	sy prior to co med? death?	opsy findings available impletion of cause of
	De C	25. Was case referred to medical examiner?	26. Place of Death			
Of Vita Physicien: this certific ral director,	0	1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	4 Nursing Hor		ence 6 □Other (Special ow injury occurred	fy)
ION Of nding Phy tth. : After this e funeral c	ation	1 ☑Natural 5 □ Pending (Month, Day Year) Injury Work	(? Yes 2 □ No		,,	
Division I or Attending after death. Director: After tin by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (So City or Town	treet and Number or Run n, State)	al Route Number,
	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the tim (Check only one) 1 Medicel Exeminer: On the basis of examination and/or investigation, in my op and manner stated.				
To the within To the comple	Z e	29b. Signature and title of certifier 29c. License			29d. Date signed (Month,	
		Microse Schedally D191	667		04-26.5	2008
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Current with 7310 (2: teliam the print)	m \$ 508	Gleu Bo	rice, Mayla	rep 51001
State Registra		31. Date filed (Month, Day, Year) APR 3 0 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year uKes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Daltimore Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 12 M 2 F -78-779 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be retitied at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Zives 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Never Married 2 Married 1 ∐Yes 2 X If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) College (1-4or 5+) WELD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) da 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Demetra -daugtily 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part Erver the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediat Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** at least 2 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificant. Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 224No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 □ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08

State Registrar

31. Date filed (Mont

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N. Calver

21202

Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Year 5:28A M THOMAS DIXON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** DOCTOR'S HOSPITAL PRINCE GEORGE'S LANHAM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1 X M 2 □ F Yrs 78 **Director** 238-40-6479 MAY 19, 1929 NC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Types 2 □ No Director MD PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4502 BURKES PROMISE DRIVE 20720 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 No 1951 If Yes, Give Year or Dates TO 1952 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 3 MWidowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11TH OFFICE ASSISTANT C.P.B. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE DIXON POLLY UNDERHILL ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONY CARROLL MCFARLAND/DAUGHTER 4502 BURKES PROMISE DRIVE BOWIE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BRENTWOOD, MD FT. LINCOLN CEMETERY 05-02-2008 of Funeral 69 22. Name and Address of Facility Marshall's Funeral Home of MD Donald R. Gray 4308 Suitland Road 20746 Suitland, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Hypoxic chephalo pith disease or condition resulting in death) Unknown /Medical Due to (or as a consequence of Examiner Advanced lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Chronic obstructivi use as the burial-tran attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy After this certificate 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 🔀 No Certification: To 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month Day, Year)

Rote Fran 7.0

ROINTAN FARAHIFAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801

Registrar's Signature

29c. License number

043446

Georgia Are Snit 3-32 S. Iran Spring MD 20902

29d. Date signed (Month, Day, Year)

4.24.08

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 08 PM **Physician** 2008 28 April Edwin Dawson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 XM 2 ☐ F Oct. 13, 1955 Wilson, Director 237-90-2251 N.C. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 √ Yes 2 □ No Director Marvland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 4800 Seton Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∏Yes 2★ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: **Black** Completed by 3 ☐ Widowed 4 反 Divorced 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Operator Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fester Dawson Addie Cotton Pages 1 and 2 should nent of Health and Mer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a tem 27 is 205 Covenant Ct. Rocky Mount, N.C. Addie Batts / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State May 3,2008 Masonic Cemetery Wilson, N.C. 4 Donation 5 Dother (Specify) 2. Name and Address of Facility Alexander S. Pope. P.A. 5538 Mariboro Pike/Forestville, Md. of Funeral Service Licensee 20747 Approximate Interval Betwe 23a. Part 1. Enter the disease or complications that caused the death. the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Immediate Cause (Find disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran physician and of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 \prod Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2K No 1 Yes 1 □Yes Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) Signature and title of o April 29, 2008 cause of death (Item 23a) (Type, Print) Paul Street S-5 Baltimore, Md. 31. Date filed (Month, Day, State Registrar APR 3 0 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	iryland		artment of <i>rtificate o</i>				giene / Reg. No.	2008	3 14037
ı	Physicia	an	1. Decedent's Name (First, Middle, L	ast)						2. Date of De Month	eath Day	Year	
	/Medic		4a. Facility Name (If not institution, g.				4b. City, Town	, or Location	on of Death	4-25-2		ounty of De	6:55AM M
art.	Funeral Director		220501799			st birthday) Yrs.	Notti If Under 1 Yes Months Day	ar If Unc	der 24 Hrs. s Min.	8. Date of Bin (Month, Date 4-12	rth	0	O. irthplace (State or Foreign Country)
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	e Mary 8a-f sh	Director	Md. Balto.		N	ottin							1 □ Yes 2 □ No X
	with the Sa or 2		10e. Street and Number 4303 Soth Avenue				10f. Zip Code 21236				10g. Citize	en of What C	Country?
	r death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		. 13. \			Origin? (S	pecify Yes or No o Rican, etc.)	D- 14		nerican Indian,
036	within 72 hours after death with the Maryland jien. jiens rathan "natural", or Items 23a or 23a-f show the Medical Evan her must be notified at	ğ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2√ N If Yes, Give Year or Dates:	0		I⊡Yes ≱⊡N					Specify:	White
2-0036	72 hou "natura	leted	15. Decedent's E (Specify only highest g	Education rade completed)	10	16a. Dece	dent's Usual Occ kind of work dor	cupation ne during n	nost of wor	king	16b. Kind	d of Busines	s/Industry
1212	J within J giene. r than "I	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		oo not use ret nder/Mai				Rest	aurant	=
gue	ld be filed lental Hygi ked other ic event, I	Be	17. Father's Name (First, Middle, Las	it)						ne (First, Middle		urname)	
Maryland	ges 1 and 2 should be it of Health and Menta If item 27 is marked or other traumatic ev	오	John Delker 19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Stre			a Griff ural Route Numb		Town, State,	, Zip Code)
	s 1 and 2 of Health a item 27 is r other trai		Deborah Delker	Wife					enue	Notting			
	ages 1 ent of H it: If iter y or oth		20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	20b. Pla		sition (Name of natory or other p	olace)	4 20	Date -2008		ation - City o	or Town, State
ža II	permit. Pages 1 Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service Lice	<u> </u>	ı	Bayv	. Name and Add	dress of Fa		-2006	Dal	LO.MG.	•
	20 E # 9		23a. Part 1. Enter the disease, or con	mplications that caused	the death					Home 9		elair	Rd.
was F	Physician	b. 1	shock, or heart failure. List only Immediate Cause (Final disease or condition	y one cause on each lin	e.			_				0	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):	Coron	(100,70	7 107 41	<u> </u>	737 45		
E		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	conseque	ence of):							
	and Alleransi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	conseque	ance of):							
58/50,	ificate be executed g physician and st the burial-transit	edical E		d.	conseque	since onj.							
	leath certifica attending ph for use as th	/Medi	IF FEMALE:	22a Hunn outcome									
ם י	the death or by the atten- iched for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 1 Pregnant at 9 Unknown	2 🗀 Fetal o	death 3	Ectopic pregna Other (specify)				23	3d. Date of d Month	lelivery Day Year
Vital Records, P	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Luneral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	þ	Part II. Other significant conditions Tobacco abuse		t not result	ting in the ur	nderlying cause	given in Pa	irt 1.		tobacco uso		to the cause of death?
eco	law re has bee	Completed	Thyroid canc	ec						24a. Was	psv	prior to	autopsy findings available o completion of cause of
ומו	in: The lificate or, pag	e Cor	hyperlipidemie 25. Was case referred to medical							1 □ Yes		death? 1 ☐ Ye	? es 2 □ No
> 1	hyslcia his cer	To B	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	R/Outpatien	t 3 DOA	34b		th (Check only ome 5 ☑ Res		□ Other (Sp	pecify)
בוס סום	ding P	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury		njuryat √ork? □Yes 2	□No	28d. Describe	how injury	occurred	
DIVISION OF	after dea after dea Director d in by the	Certification:	3 Suicide 6 Could not determined	be 200 Place of Inju						28f. Location (City or To	Street and wn, State)	Number or i	Rural Route Number,
	ne Hospita n 24 hours ne Funera oletely fille	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best of the miner: On the basis of and manner sta	examination	ledge, death on and/or in	n occurred at the vestigation, in m	e time, date ny opinion,	and place death occu	e, and due to the arred at the time	cause(s) a , date and p	and manner place, and di	as stated. ue to the cause(s)
,	To the withing the complete co	ž	29b. Signature and title of certifier	ma	1111	es	1	onse numbe					nth, Day, Year)
	le		30. Name and address of person who	completed cause of de	eath (Item :	23a) (Type.	Print)	-		Baltimon		1 71	
	Sta 'Registra		31. Date filed (Month, Day, Year) APR 3 0	32. Registra	r's Signatu	ire	Constitution				4	Ea (C	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Gpr. acies Elmer L. Dehn /Medical As. Facility Name (If not institution, give street and number)
Baltimule Woshington Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Arma Arunde Glen Burne Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 217-46-4099 Yrs. 60 1947 MD 16 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 759 213th Street 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 21⁄2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) Construction Residential 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fil Health and Mental H em 27 is marked otl ther traumatic ever Elmer Dehn Sarah Patti ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trauonce. 4404 Fairhaven Avenue, Baltimore, MD 21226 Sarah Dehn (mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemeterv 2008 21. Signature of French Service Lice. Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complication shock, or heart failule. List only one cau immediate Cause (Final tallure **Physician** Le spiratury disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 months neumonia Sequentially list conditions, lany course in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner obstructive physician and the burial-transit Chronic Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ lation; Obstructive sleep a mey 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an cate has t autopsy performed? /es 2 2 No To the Hospital or Attending Physician: The within 24 hours a 'er dea'h.

To the Funeral Director. After this certificate I completely filled in by the funeral director, pag 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

death certificate be executed Box 68760 P.O. Division or Vital Records,

Baltimore, Maryland 21215-0036

29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

10022483

28, 200f

WD lacchs

on who completed cause of death (item 23a) (Type, Print) 305 Nospital

Dr. Gley Burnie, Mn 2106

State Registrar

31. Date filed (Month, Day, Year) APR30 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2008 14039 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 2008 3:00 A M Richard Lee Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Catonsville Summit Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1, M 2 □ F **Director** Feb. 26, 1926 216-16-9666 82 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1∏Yes 2☐No **Funeral Director** MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 102 S. Kossuth Street 21229 12. Was Decedent Ever in U.S.
Armed Forces?

MXYes 2□No WW II
IYes, Give
Year or Dates: Navv 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: Be Completed by Specify: Black 3 ☐ Widowed XX Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Retired Coast Guard US Coast Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Otis McCetle Minerva Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherman Davis/Son 9150 Gracious End Court, 301, Columbia MD 21046 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of I Important: If ite any injury or otl 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 30, 2008 Owings Mills 4 Donation 5 Other (Specify) Garrison For. Vet. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Betts Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 □Yes 1 ☐ Yes 2 ∏No XX 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation **MX**Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Eleva & sperk

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MD 516 N Rolling Road #108, Catonsville MD 21228

asanthalcama mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M Vasantha Kumar,

		Please T		nt in Black In aryland / Depa						14040
		State Registrar		Ce	rtificate of	Death		Reg. No.		
		1. Decedent's Name (First, Middle, Last)					Date of De Month	ath Day	Year	3. Time of Death
Physici /Medi		DEBRA EDV	ARDS				April	25	2008	07:55 PM
Examir		4a. Facility Name (If not institution, give	street and number)			r Location of Death	1	4c. County		
-patr		Sinoi Hospital of				ore City		N/		(0)
Funeral		5. Social Security Number 6. Sex	7.Ag	e (In yrs. last birthday) = 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Cour	
Director		217-66-4043		51 Yrs.			Oct. 13	3 1956	MAH	RYLAND
'land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
Mary 3-f sh	to	MARYLAND N/A			BALTIMOR	EΕ				1 XYes 2 No
h the	Director	10e. Street and Number	-		10f. Zip Code			10g. Citizen of V	What Cour	ntry?
5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Evan in at the notified at	le l	1700 GWYNNS FA	ALLS PKWY	2nd flr	212	217		U.S.	Α.	
ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. Rad Blad	ce - Americ	
36 afte	by F	1XXNever Married 2 ☐ Married	1 ∐ Yes 2X∑X If Yes, Give	No	1 □Yes XXNo	Specify:		Specif		
hours	g p	3 Widowed 4 Divorced	Year or Dates:	160 Door	edent's Usual Occup	nation		16b. Kind of B		ACK
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21215-0036 d within 72 hours aff giene. r than "natural", or the Medical Evant	E	Elementary/Secondary (0-12)	College (1-4or 5		OUET SERV	/ER		SHERT	М/ТО	WSON NORTH
iffled other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	, Maiden Surnan	ne)	
Maryland Id 2 should be file Ith and Mental Hy 27 is marked oth traumatic event	To B	AQUILA EDWARDS				CARRIE	POWELL			
ary shoul and M s mar	Г	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Numb	er, City or Town,	, State, Ziç	Code)
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanties and the notified at		Lakia Waddell/Dau	ghter	2334	Reisters	stown Rd.,	Balti	more, Ma	ıryla	nd 21217
es 1.2	1 5	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F	lameual from Ctata	20b. Place of Disponentery, cre	osition (Name of matory or other pla		Date	20c. Location	- City or To	own, State
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		4 □ Donation 5 □ Other (Specify)	emovar from State	KING MEM	ORIAL PAR	RK	2-08	BALTIMO	RE,	MARYLAND
Baltimore, permit. Pages 1 ar Department of Hes Important: If item any Injury or othe		21. Sign sure of Funeral Service Licens	e d	2 W	2. Name and Addre	ess of Facility BROWN CON	MIINTTY	FUNERAT	, ном	E P.A.
ਜ਼ ਫ਼ੵਫ਼ਫ਼ਖ਼	W 1	- Darbara C	Hous			RTH AVENUE				
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused ne cause on each li	the death. Do not er ne.	nter the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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* /Medical		resulting in death)	Due to (or as	a consequence of):	3 3	¥ .				1
Examiner	_	Sequentially list conditions,	Acute	hypoxic H	uprotery	tailure				3 days
7.5 E	Examiner	if any leading to immodiate cause. Enter Underlying Cause (Disease or injury	Differ to (or de	a consequence of):	1					2 /
6 executed lian and urial-transit	xan	that initiated events resulting in death) Last	Dueto (or as	a consequence of):	rgency.					3 days
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. Box 6876 death certificate be attending physici d for use as the b.	Physician/Medica									
Box 6876 sath certificate br attending physici for use as the bu	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Da	ate of deliv	rery
Beath death	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a		☐ Ectopic pregnand ☐ Other (specify) _	су			onth	Day Year
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	by PI	Part II. Other significant conditions con	ntributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use con	tribute to t	the cause of death?
guire quire en sig uld b							10	Yes 2 No	3 ☐ Pro	bably 4 ☐ Unknown
of Vital Records, Physician: The law requires the this certificate has been signer and director, page 2 should be do	Completed						24a. Was		Were auto	opsy findings available
The I	E							ormed?	death?	ompletion of cause of
Vital F ician; Th certificate ector, pag	Be C	25. Was case referred to medical				26. Place of Deat				
of Vita Physician: this certific ral director, I	To E	examiner? 1 ☑ Yes 2 ☐ No	lospital: 1 Inpati	ent 2 ER/Outpatie	ent 3 DOA Ot	her: 4 🗆 Nursing Ho	ome 5 Res	idence 6 □Ot	her (Spec	ify)
on of Vita ding Physician; th. After this certifics funeral director, p	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	ury 28b. Time	of 28c. Inju	ry at rk?	28d. Describe	how injury occur	rred	
Division or Attending after death. Director: After	Certification:	2 Accident investigation		1	M 1 []Yes 2□No				
or Att	Ě	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	ury - At home, farm, s tc. <i>(Sp</i> ec <i>ify)</i>	treet, factory, office		28f. Location City or To	(Street and Num wn, State)	ber or Rur	al Route Number,
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ▼ Certifying Phy (Check only 2 ■ Medical Exami one)	sician: To the best ner: On the basis of and manner st	of my knowledge, dea of examination and/or i	im occurred at the finvestigation, in my	opinion, death occu	, and due to the rred at the time	, date and place	, and due	to the cause(s)
o the ithin 2 o the	Mec	29b. Signature and title of certifier	and manner St	ated.	29c. Licen	se number		29d. Date signe	ed (Month	, Day, Year)
7 wit		Domalay MD			RE5-			April 2		
			mpleted source of	dooth (Itom 22a) (T				.,,,,,	- , - (
0		30. Name and address of person who co								
No.	ate	31. Date filed (Month, Day, Year)	32. Bigist	pital of B rar's Signature	1					
Regist		APR 3 0 20	108	in the st	parte					
DHMH 17 Rev 1/	2001									

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 26 2008 **Physician** MELVIN Ε. **EDWARDS** 1:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7147 Baltimore Annapolis Blvd. Glen Burnie Anne Arundel County Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1**X** M 2□ F 219-58-1568 57 Apr 3, Virginia **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Glen Burnie Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7147 Baltimore-Annapolis Blvd., 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Š Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Car Wash Elementary/Secondary (0-12) College (1-4or 5+) Equipment Co. 12 Mechanic Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Edwards Louise Colley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 19a. Informant's Name/Relationship (Type. Print) Janice E. Edwards 7147 Baltimore-Annapolis Blvd., Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland Glen Haven Mem Pk 5/3/08 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility}
McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Md. 21. Signature of Funeral Sendes Licensee Kevin E Ecker 21122 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NON Small Cell Omont6 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Bhain metastesi Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tyles 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed res 2 4 To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Presidence 6 □Other (Specify) 27. Mann of Death 1 atural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janul Misles Gleane 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician WILLIAM ELMAN 1:30 PM April 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN NURSING HOME BERLIN | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 03/03/1932 9. Birthplace (State or Foreign Country) ocial Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 579-68-2765 76 CANADA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Ex-miner must be notified at 1 ☐ Yes 2 No MD WORCESTER Director BERLIN 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 SEAGRAVE LANE 21811 CANADA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural". 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the M Elementary/Secondary (0-12) PROCESS SERVER LEGAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEAH UNOBTAINABLE HARRY ELMAN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 SEAGRAVE LANE, BERLIN, MD 21811 ROCHELLE ELMAN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MIKRO KODESHO BETHOO ISRAEL CONGREGATION 1 D Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CONGREGATION 04/29/2008 |BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Mark 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardisvascula disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Por in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No ed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably ★Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s has autopsy certificate 1∐ Yes 25. Was case ref Be ed to medical 26. Place of Death (Check only one) Hospital: Other: Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 Z No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No death. 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending within 24 hours after death

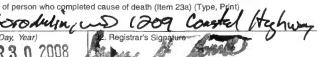
To the Funeral Director:
completely filled in by the

State

29a. Certifier

Medical

31. Date filed (Month, Day,



and manner stated.

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Stete Registrar		State	of Mary	yland /	•	rtment ificate			and M	lental Hy	giene Reg. No.	- 000	3	14043
			1. Decedent's Name	e (First, Middle	Last)								2. Date of De	ath Day	/ Ye	ar	3. Time of Death
	Physici /Medio		DOLORES CA	THERINE 1	FARRELL								April	214	300		2:30 P.M
	Examin		4a. Facility Name (/	f not institution,	give street and i	number)			4b. City, To	wn, or	Location of	of Death	•	4c.	County of D	eath	
	<u> </u>		BALTIMORE						GLEN			Od Hee			NNE ARU		
	Funeral Director		5. Social Security N	52	6. Sex 1 M 2 T F		n yrs. last b	Yrs.	If Under 1 Months [Days	If Under Hours	Min.	8. Date of Bir (Month, Da FEB 20 1	929	9.	Countr	ce (State or Foreign y) PA
	and w		Usual Residence of 10a. State	10b. County		10	Oc. City, Tov	vn or Loca	ation							100	d. Inside City Limits
	Maryl 1 • hc	ō	MO	DALTIMO	DE.		BALTIM	DE.									1 ☐ Yes ŽŽ No
	288	Director	MD 10e. Street and Nur	BALTIMO mber	KE		DALITE	JKL	10f. Zip C	ode				10g. Citi	izen of What	t Countr	y?
	3e or		1315 SLEE	DV HALLAN	JIN				212	20					USA		
	deeth	Funeral	11. Marital Status	FT HOLLO	12. Was De	ecedent Eve	er in U.S.	13. W	as Deceder	nt of His	spanic Ori	gin? (Spe	cify Yes or No	o-	14. Race - A		
336	within 72 hours after deeth with the Maryland one. then "naturel", or iteme 23e or 28e-f ehow the Medical Examiner must be notified at	by Fur	1 Never Marri		If Yes,	Forces2 s 2 1 No Give r Dates:			Yes, specify □ Yes 2 X		Specify:		Hican, etc.)		Black, V Specify:	WHIT	
7 5	2 hou	ted		15. Decedent	s Education	Α.	16	a. Decede	nt's Usuat	Occupa	tion			16b. Ki	ind of Busine	ess/Indu	ıstry
7.7	hin 7	Completed	Elementary/Seco		t grade complete	a) (1-4or 5+)		lite. Di	ind of work O NOT use	retired)	unng mos	t or worki	ng				
212	od wit	NO.	12					SE	AMSTRE	SS				GA	RMENT		
J. B	al Hy f oth	Be C	17. Father's Name	(First, Middle, L	.ast)						18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
自	Wenta	10	FRANCES A	NKUDOV I CH							MAR	RTHA W	ILLIAMS				
a ₇	and I		19a. Informant's Na	ame/Relationsh	ip (Type, Print)		19	b. Mailing	Address (S	Street a	nd Numbe	er or Aura	al Route Numb	er, City o	r Town, Stat	te, Zip (Code)
Z Z	and 2 palth n 27		MICHAEL	E. FARREL	.L	SON					E PLAC		MARKET,				
Dolones FARRE 11—altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23e or 28a-1 ehow eny injury or other treumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 XXBurial 2 4 □Donation	Cremation	3 □Removal fro ecify)	1		ery, crema	ition (Name atory or other CEMET	er place	1	.29.2	008		IMORE,		n, State
Ď¢ Balti	permit. Depertmitimports eny inju			oneral Service	1-1	M011	hΩ		Name and				JRNIE, MD	2106	1		
			23a. Part . Enter to shock, or hea														Approximate
9	Physician /Medical Examiner		shock, or hea Immediate Sause disease or condition resulting in death)	(Final	a. Due	to (or as a co	esi5	of):			iden			-			nterval Between Onset and Death
8760, «	ate be executed thysicien end the burial-transit	dicai Examiner	Sequentiatly list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nmediate orlying injury	c. Due	to (or as a co	onsequence	of):				4					
P.O. Box 68	Physician: The law requires that the death certifica this certificete hes been signed by the attending ph ral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months? ⊒No		e birth 2 [egnant at tim	Fetal deat		Ectopic preg Other (spec						23d. Date of Month		y Day Year
	quires thai in signed t uid be det	۵	Part II. Other signif	ficant conditio	ns contributing to	death but n	not resulting	in the und	derlying cau	ise give	n in Part t				1		e cause of death? bly 4 Unknown
Division of Vital Records,	The law requir te hes been si age 2 should	Completed											24a. Was auto perf 1 \(\text{Yes}		deat	e autop to com h? Yes 2	sy findings available pletion of cause of
tal	ılclan: Th certificete rector, pag	0	25. Was case refer	red to medical	A						26. Place	of Death	Check only			103	
5	ysician: The is certificate he director, page	To B	examiner?	No	Hospital:	npatient	2 🗆 ER/C	utpatient	3□ DOA	Othe	-		me 5□Res		6 Other (Specify)	
5	g Ph er thi		27. Manner of Deat		28a. Da	te of Injury onth, Day Yo		Time of		. Injury Work			28d. Describe			,,	
<u>.</u>	Attending ir death. ector: After by the fune	ate	1 Natural 2 Accident	5 🔲 Pending investig		Ontil, Day 1	ear)	Intury	м		es 2 🗆	No					
Divis	of or Atte	Certification;	3 Suicide 4 Homicide	6 □ Could n determi	ned 288. Pla	ice of Intury	· At home, Specify)	tarm, stre	et, factory,	office			28f. Location City or To			r Aural	Route Number,
	To the Noepital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	1 Certifying	g Physicien: To Exeminer: On the and m	the best of n basis of ex anner stated	camination a	ge, death nd/or inve	occurred at estigation, in	the tim	e, date an inion, dea	nd place, ath occurr	and due to the red at the time	cause(s)) and manne d place, and	or as sta	ted. the cause(s)
	vithin o th ompl	Me	29b. Signature and	title of certifier					29c. 1	License	number			29d. Da	te signed (M	fonth, D	lay, Year)
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	10		30. Name and oddr	es ot person	who completed co	ause of deat	th (Item 23a	(Type, P	rrint)	len	Bru	roll	, mo	יועכ	61.		3
	Sta		31. Date filed (Mon		2008	Registrar	Signature	Son	alle)	V- V			1	240			
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AMAND TITING 15 per EH, C878, 4/30/08, US
State of Maryland 7 Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2008 4:45 PM Physician EROM /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Road WAMPIGE 102 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Hours Min. **V**M 2□F 1930 Yrs. MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ansit if item 27 is marked other than "natural", or Items 23a or 28a-f show ant; if item 27 is marked other than "natural", or Items 23a be notified at ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director MD Middle River Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 14. Race - American Indian, White etc. 21220 Funeral 102 Wampler Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify Completed by 3 Nidowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Paving Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Borger 2 George Foltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan Foltz/Daughter-In-Law 15433 Revere Drive New Freedom, PA 17349 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐€remation 3 ☐ Removal from State Apr 25 Beltsville, Maryland 4 Donation 5 Other (Specify) 2008 Chesapeake Crematory Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01443 Cremation and Funeral Alternatives e Bitter pproximate Interval Between Onset and Death 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician MEta Stati /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infiniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence of Examine sician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician s the burial Division or Vital Records, P.O. Box 68760, by Physician/Medical SB attending p IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy perform 2 ☐ No 1 ☐Yes certificate 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 1 🗌 Yes 1 🔲 Inpatient 4 Nursing Home ပို this Il Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 2 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of g 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHYARUS F 140 55013 ms 3900 Loch RAVEN Blud BAHTMORE, MD 21218 egistrar's Signature 31. Date filed (Month, Day, Year) 32, State APR 30 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** P^{M} 2008 2:45 April 28 Charles C. Feuerherd, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 418 Kingwood Rd. Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 **⊠** M 2 □ F Director 12/11/21 Maryland 86 215-14-5598 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Evaminer must be rediffed at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2 No Director <u>Anne Arundel</u> Linthicum Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21090 USA Funeral 418 Kingwood Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 對Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: \$ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Masonary Contractor Masonary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adolf Feuerherd Katie ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linthicum, Md. 21090 Charles C. Feuerherd, Jr. / Son 413 Kingwood Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery : 5/2/08 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service I 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between Onset and Death nplications that caused the death.
one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician moyen disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** eumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician: The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year signed by the a d be detached for 5 Other (specify) ∃Yes 2 □ No Ö 9 Unknown 9 Unknown Δ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Rolly RD Ballomo H778 1120 MUD WOY 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:50 A ^M Peter John Feddor Apr 15, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard 10583 Spotted Horse Lane If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 077-30-6580 68 NY Director Jan 28, 1940 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Completed by Funeral Director MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10583 Spotted Horse Lane 21044 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Section Manager Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Peter Feddor Freida Nelson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathleen M. Feddor Spouse 10583 Spotted Horse Lane Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State rematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a con equence of) /Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed DE S burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ntributing to death but not resulting in the underlying cause given in Part I. ð 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 \(\sum \) Nursing Home Hospital: 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 1 Tyes 1 Inpatient P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

15 State 29b. Signature and title of

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1, Decedent's Name (First, Middle, Last) Day Jeanne Marie Griffin April 29 2008 8:35p М 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carrol1 Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 25 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 217-26-1861 78 Oct. 1929 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21784 1442 Buckhorn Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced white 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) Applied Physics Lab secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

Margaret Annen

507 Hoods Mill Rd., Woodbine,

20b. Place of Disposition (Name of cemetery, crematory or other place)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

MD 21797

20c. Location - City or Town, State

Physician /Medical **Examiner** 1 - For State Registrar

10a. State

Director

Funeral

þ

Completed

Be

2

MD

William Sadler

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print) Stephanie Reid (daughter)

Physician

Examiner

Funeral

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Examinatment be notified at once.

/Medical

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be execute as nse for ed by the detached page 2 s has this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

11 I Burial 2 V I Cremation 3 L Hemoval from State 1	unty Cremation 5-1-08	Sykesville,	, MD
21. Signature of Funeral Service Licensee	22. Name and Address of Facility Haigh	Funeral Home	& Chapel
Dag Jaight Herbert	P.O. Box 195 Sykesvil		
23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	plasm	iratory arrest,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Line, Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Due to (or as a consequence of C.			Ī
that initiated events resulting in death) Last C. Due to (or as a consequence of d):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of d Month	elivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the Clost idea Difficule Enterechas	the underlying cause given in Part I.	3e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐	to the cause of death? Probably 4 Unknown
Demention		4a. Was an autopsy performed? □ Yes 2 ☑ No 24b. Were a prior to death?	
25. Was case referred to medical	26. Place of Death (Che	ck only one)	
examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outs	patient 3 DOA Other: 4 Nursing Home	☐ Residence 6 🗹 Other (Sp	pecify) IN PATIENT LOCKE
2 Accident investigation		escribe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office 28f. L	ocation (Street and Number or lity or Town, State)	Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and d /or investigation, in my opinion, death occurred at	ue to the cause(s) and manner the time, date and place, and d	as stated. ue to the cause(s)
29b. Signature and title of certifier	29c, License number	29d. Date signed (Mo.	nth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (The first of the completed cause of death (Item 23a) (The first of the cause of de	Type, Print) Colberty RD Elders	ing up 2178	y
31. Date filed (Mortul, Day, Teal)	Jan Maria		

DHMH 17 Rev 1/2001

State

Registrar

APR 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle Last). Month **Physician** /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner uture If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year Social Security Number 6. Sex Year **Funeral** Months 1 □ M 2 12 Yrs 1912 Caroling Director Usual Residence of Decedent 10d. Inside Çity Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 Nes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Harlem Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never-Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Baltimore, Maryland 21215-0036 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sorter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Lewis ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Typal. Print) Betty daughter-in-law 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition tery, crematory or other place) 1 Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. A of oximate I of rval Between set and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final 3411 Physician DEMONTA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONTY Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Munia that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1☐ Yes 2 ☑ No 5 ☐ Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 2 No 3 Probably 4 Nonknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy perform 2 N 1 ☐ Yes 2 HO 1□ Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 TYes 2 Certification: To After th funeral 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day,

MARGHESE

APR 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 25 2008 Elizabeth S. Georgiev April 11:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct. 24, 1937 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 206-50-1851 70 Director Bulgaria Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 X Yes 2 ☐ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~ any injury or other traumatic event. 20878 121 Kent Oaks Way United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Institutes Elementary/Secondary (0-12) College (1-4or 5+) of Health Pharmacist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stoian Gurkovsky Ivanka Nacheva 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vassil Georgiev/Husband 121 Kent Oaks Way, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery crematory or of Gate of Heaven Cemetery 1
☐ Burial 2 □ Cremation 3 □ Removal from State April 28, 2008 Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville Inc. 300 West Montgomery Avenue Rockville, Maryland 21. Signature of Funeral Service Licenses non M01360 233 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arrest ulmonary Condina disease or condition resulting in death) 10 minutes /Medical Due to (or as a consequence of). Examiner 0615 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) The law requires that the death certificate be executed the bunial-transit and Due to (or as a consequence of): attending physician for use as the buna Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 12 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

QIUFANG

29c. License number

Medical Center Prive.

00065505

29d. Date signed (Month, Day, Year)

2008

and manner stated

M.D

9901

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHENG

APR 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Day Month **Physician** 25 Agnes M. Greek /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🖺 F 78 09/29/1929 Pennsylvania 162 24 0327 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Project Examiner must be notified at 1 ☐ Yes 2 No Anne Arundel Baltimore Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 5813 Redmond Street 21225 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2X No Specify Yes Give Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Deganich Anna Yacubich ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3800 Tabor Road Owings Mill, Maryland 21117 Beverly Feldman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/28/2008 Holy Cross Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 2001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee 4001 Ritchie Highway monuerule 23a. Par 1. Enter the disease, complications that caused tr shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician 3 2040 disease or condition resulting in death) 25/5 /Medical Due to for as a consequence of): ocard Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 Other (specify) □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/1 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Examiner Physician: The law requires that the death certificate be executed burial-trar and Division of Vital Records, P.O. Box 68760,₹ physician the as attending use for the detached by funeral director, page 2 should be has this After To the Hospital or Attending

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

al Hygiene.

of Health and Menta item 27 is marked

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

3 State Registrar

31. Date filed (Month, Day, Year)

0

29b. Signature and title of certifier

(Check only

Wal 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year ZDay ZZ **Physician** 3:20 m RANDALL H. GREENLEE Z008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BLAKEHURST TOWSON 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) MARYLAND If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**⊠**M 2□ F 216-24-6757 80 Yrs Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No TOWSON **Funeral Director** MD BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1055 WEST JOPPA RD 21204 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BG&E EXECUTIVE BG&E EXECUTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT E. GREENLEE SALLY HAGNER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK S. KOONTZ(ATTY) 7 ST. PAUL ST. BALTO., MD. 21202. 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town. State cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 04/24/08 BALTO CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Alherescherotic eardronasculas disease /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit Squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical Due to (or as a consequence of): Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? á 1 | Yes 2 No 3 | Probably 4 | Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? eral Director: After tilled in by the funera 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completely filled in by 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 31. Date filed (Month, Day, Year) APR 30 2008

Neme end address of person who completed

29b. Signature and title of certifie

60 agistrer's Signature

of death (Item 23a) (Type, Print

cause

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Apr 24, 2008 **Physician** 3:35 P M Gloria Jean Gadsden /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** Irvington **Future Care** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours Min. 1 M 2 F NY Dec 16, 1954 53 Director 090-46-3850 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Catonsville Director **Baltimore** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21228 407 F Shade Tree Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify: Specify: Black 2 S ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna L. Rose ည William L. Gadsden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 407 F Shade Tree Place Catonsville, MD 21228 William Augustono 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Apr 26, 2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) **Bayview Crematory** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCULAR ACUDENT Physician /Medical Due to (or as a consequence of): MPERTENSION Examiner UNCONTROLLED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit DIABE TED Due to (or as a consequence of) O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 UNKNOWN origin 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1∐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Officers After this certificantell filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide within 24 hours

To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00056942 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLATEE 3H BATTIME ND 2147 MANNINDA 300 Arris on 31. Date filed (Month, Day, Year) 2. Registrar's Signature

Registrar

APR 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2008 6:18 PM April Alise Hayes Harlan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Health & Rehab Center Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🛣 F 86 Virginia Feb. 10, 578-24-5359 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TyYes 2 □ No MD Bethesda Director Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20814 USA 5721 Grosvenor Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify Specify Black þ 3 ☐ Widowed 4 🛣 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) US Coast Guard Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alma Fields John K. Hayes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2509 Colebrook Drive Temple Hills, MD 20748 Robert Harlan, Jr. (Son) item 27 other t Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If it injury or 4/26/08 Shumansville, VA Mt. Tabor Bapt. 4 □ Donation 5 ☐ Other (Specify) P.O. Box 395 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any C.W. Edwards Funeral Home Bowling Green, VA nt1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate cause (Final disease or condition resulting in death) ongel Isne Physician /Medical Due to (or as a consequence of): Examiner St SC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner terme the burial-tra Due to (or as a consequence of): physician Kenal for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed3 1 ☐ Yes 2 ☐ No 1□ Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending the Funeral Director: npletely filled in by the hours

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

within 24

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To the

State Registrar

31. Date filed (Month, Day,

29b. Signature and t

Registrar's Signature 32

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30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 725 Anthony Heckner Jacob 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE 474 HOTPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oct 7 193 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑** M 2□ F 77 213-28-2110 MD **Director** 1930 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 27 No Carrol1 Sykesville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2810 Kaywood Place 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ۵ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) bakery baker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob A. Heckner Anna Plum ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cecelia Ciampa (niece) 4855 Cherry Tree Ln., Sykesville, MD 21784 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Lorraine Park Cem. 5-2-08 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Haight Sperbert P.O. Box 195 Sykesville, 1 MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ひれりら HYPOX 1c ENCEPHALOCATHY /Medical Due to (or as a consequence of): **Examiner** EPSUS DARG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 12 DAYS DIFACILE COUTIS MUIGINGLOS Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ IRIL LATION 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☑ No 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Pmpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

burial-trar law requires that the death certificate be exect attending physician as the for use P.O. the signed by Division of Vital Records, been has or Attending Physician: The this certificate After

with the Maryland

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If flean 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the reaction.

Baltimore, Maryland 21215-0030

Pages 1 and 2 should be

detached should be page 2 director, funeral 24 hours after death • Funeral Director: filled in by the Hospital the within ?

State 'Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR30

122 2x 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

000

29d. Date signed (Month, Day, Year)

Since HOSPITAL OF BALTINORE

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4/27/2008 0830 Thomas Bourdon Heartwell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min DEMM 2 F 226-14-9376 89 12/30/1918 Director VÁ Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinar must be notified at once. MD Anne Arundel Arnold 1 ☐ Yes 2XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 853 Twin Harbor Dr. 21012 USA **Funeral** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No ģ Specify White Specify. 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Harrison Heartwell Bessie Bourdon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Hobaugh Daughter 853 Twin Harbor Dr. Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Blandford Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5/5/2008 Petersburg, VA 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service L Vati 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical attending properties for use as use as IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed 1 □ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral To the Hospital or Attending Pleath within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

31. Date filed (Month, Day,) 2008 V

29b. Signature and title of certi

ounce 32 Redistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD tow402P Annes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 10:03 PM **Physician** 2008 April 2 CORALIE JANE HILL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD BEL AIR UPPER CHESAPEAKE MEDICAL CENTER Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours 1 □ M 2 1 F 1942 Maryland June 18, Director 215-40-5364 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State rr than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 1217 Conowingo Road Funeral 14. Rece - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3altimore, Maryland 21215-0036 ģ 3 Nidowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government 12 Secretary permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Louise Pearce Samuel Nathaniel Booth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 701 Lanark Ct., Bel Air, MD 21015 Cynthia Lynn Rybak / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grdn 4-30-08 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig/ re/ Fune Servic use 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 diac or respiratory arrest, Charles Fruch Approximate Charles are the Reference onset and Death aused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest art1. Enter the disease, or complications, or heart failure. List only on-Immediate Ceuse (Final clisca Exame **Physician** resulting in death) Due to (or as a consequence of): /Medical Examiner 40005 Stac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): vision or Vital Records, P.O. Box 68760, physician sthe burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Tubcarde Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 24 hours after death. • Funeral Director: After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and eddre

rec

31. Date filed (Month, Day, Year)

APR 3 0 2008

of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

D0053568

law

8-02917		Please Type or Print in Black Indelib			gible.	
amoth Haynie		Registrar	e of Death	Re	eg. No. 200	8 1405
Physicia ledical Exami	2007	1. Decedent's Name (First, Middle,Last) Lamoth Haynie		2. Date of Dear Month April 13, 2	Day Year	3. Time of Death 2044 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Death	
		3912 Clark Street	College Park	les 10 Date of Bir	Prince George	
Funeral Director		5. Social Security Number 577-70-6111 1 X A 2 F		Januar	th MANDD/YYYY) 9. Birth 1950 Foreign Cou	untry) WashDC
amy	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
Maryland 28a-f show	ctor	Maryland Prince George's Ft Washi				1 Yes 2 No
or 28a-	Direc	10e. Street and Number 7220 Woodhollow Terrace	10f. Zip Code 20744		0g. Citizen of What Coun United State	,
yith the			3. Was Decedent of Hispanic Origin? (
or item	Funeral	1 Never Married 2 X Married Armed Forces?	If Yes, specify Cuban, Mexican, Pue		White, etc.	
ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:			ack
2 hours			cedent's Usual Occupation (Give kind ring most of working life. DO NOT use		16b. Kind of Business/li	ndustry
036 ithin 7. me. r than Jedical	Completed		ntract Specialist		GSA	
15-00 filed wit Hygien d other , the Ma	S	17. Father's Name (First, Middle, Last) Titus Haynie		me (First, Middle,	,	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	To Be	-	Mailing Address (Street and Number			, Zip Code)
MD id 2 shouth and m 27 is aumatic			080 Salt Marsh Co			
		1 V Burial 2 Cremation 3 Removal from State crematory	Disposition (Name of cemetery, or other place)	ril 18,	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Her Important: If ite		4 Denation 5 Other Specify:	ction Cemetery 20	08	Clinton,	Maryland
Baltimo permit. Page Department of Important: injury or oth		21 Signalur, Truneral Fervice Lies Fee	22. Name and Address of Facility	Robert G.	Mason Fune	ral Home Inc
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not e	1661 Good Hope Ro	c or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	8 4	failure. List only one cause on each line. Immediate Cause (Final disease a. Undetermined				Death
		or condition resulting in death) Due to (or as a consequence of):				
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
1.	Examiner	cause. Enter Underlying Cause (Ulsease or injury that initiated events resulting in death). Last Due to (or as a consequence of):				
and and -transit	cal Ex	d				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pre	gnancy	23d. Date of deliver	y Day Year
OX 6 ath cer	sicia	Pregnant at time of death 5	Other (Specify)		Į.	
D. Be t the de by the a	Phy	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did 1	tobacco use contribute to	the cause of death?
ires that the signed by	ģ			1Ye	es 2 No 3 Pro	bably 4 🗸 Unknown
Division of Vital Records, lead or Attending Physician: The law requires its after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed		<u>-</u>	24a. Was		utopsy findings available completion of cause of
Recol The law icate has	omp				ormed? death?	
Vital Rec ysician: The l his certificate director, page	BeC	25. Was case referred to medical examiner?	26.Place of Death (Che	eck only one)		
f Vid	ို	1 Yes 2 No Tospital 1 Inpatient 2 ER/Out	patient 3 DOA Other; Number of Injury 28c. Injury at Work?	rsing Home 5	Residence 6 Othe	r: Scene
ion of tending Pheath.	tion:	1 Natural 5 Pending Fr. J. // 1.2 / 0.9 Fr. J	1 Ves 2 No	unk	,	
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Divis spital or At tours after d neral Direct filled in by	Certification:	4 Homicide determined (Specify) found at r	esidence	Colleg	State) 3912 Clar e Park, MD	rk St.
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) Wedical Examiner: On the basis of examination and/or inv				
To t with To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
		Tarko Hegmp	O.C.M.E.		April 14, 2008	
DK Dend.		30. Name and address of person who completed cause of death (Item 23a)				
01		Tasha Greenberg MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street, Baltimore,	MD 21201		
St Regis	tate trar	31. Date filed (Month, Day, Year) APR 3 0 2008 32. Registrar's Signature	posti			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** :43 PM 26 HOIMES 2008 rie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore of Manyland University If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign Country) cial Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 N Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits State 1 Dres 2 No Mar Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 212 Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s, and or other traumatic event, the Medical Examiner must Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Yes. Give 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) tom 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any Injury or other trains 20b. Place of Disposition (Name of 20c. Location 20a. Method Disposition 1 Usurial 2 □ Cremation 3 ☐Removal from State Memoria 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer | Service Licensee 22. Name and Add 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Inte /al Between Ons and Death Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐ Yes 2☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has t irector, page 2 s 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

22 S. Green Street 32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rosenblat

29c. License number

1972707206

Bathmore

MD

29d. Date signed (Month, Day, Year)

4/26/08

		For State Registrar	State of Maryland / De	partment of Health a ertificate of Death		Reg. No. 2 U	14059
Physici		1. Decedent's Name (First, Middle, Last) Freddie Juni	or Horner		2. Date of De Month	Day 2008	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of	Death	4c. County of Death	h
Funeral Director		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last birthdom) 7. Age (In yrs. last birthdom) 7. Age (In yrs. last birthdom)	ay) If Under 1 Year If Under 2	4 Hrs. 8. Date of Bi	rth 9. Birth	nplace (State or Foreign untry) Ohio
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or				10d. Inside City Limits
ne Mary 8a-f sh	ctor	Maryland N/A	Br	ooklyn 10f. Zip Code		10g. Citizen of What Co	1 ☑ Yes 2 No
a or 2	I Dire	10e. Street and Number 3600 Tenth Str	eet	21225		U.S.A.	
ING Z IZ 13-UU30 be filed within 72 hours after death with the Maryland hal Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican □ Yes 2 1 No Specify:	jin? (Specify Yes or N , Puerto Rican, etc.)	Specify: Wh	e, etc. nite
"natural", or	leted	15. Decedent's Educ (Specify only highest grade	completed) (G	ecedent's Usual Occupation live kind of work done during most ie. DO NOT use retired)	of working	16b. Kind of Business/	
d within 72 giene. Ir than "nai the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Driver		Baltimore	e City
/lang Z	a	17. Father's Name (<i>First, Middle, Last</i>) Fred Frank	clin Horner	_	r's Name <i>(First, Middle</i> tna Dil		
lary	2	19a. Informant's Name/Relationship (Type Heather M. Horner	pe. Print) 19b. N	lailing Address (Street and Numbe .64 Mary Kay Cou	r or Rural Route Num rt, Linthi	ber, City or Town, State, 2 cum, Marylar	Zip Code) nd 21090
altimore, IV mit. Pages 1 and partment of Health portant: If Item 27 y injury or other to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of D	isposition (Name of crematory or other place)	Date 05-02-08	20c. Location - City or Sykesville	
baltimo permit. Page Department o Important: If any injury or		21. Signature of Funeral Service License 23a Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do not	22. Name and Address of Facilit McCully-Polynia 237 East Pataps enter the mode of dying, such as	k Funeral co Ave, Ba cardiac or respiratory	Home P.A. 1timore, Mar	cyland 21225 Approximate Interval Between Onset and Death
Physician /Medical		finmediate Cause (Final disease or condition resulting in death)	Metastatic C Due to (or as a consequence of)	olon Carrier			month
ecuted and transit.	Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)				, morring
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O, Box 63 he death certific the attending p thed for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	elivery Day Year
S, P.	by Ph	Part II. Other significant conditions co	• •	he underlying cause given in Part I		d tobacco use contribute	. /
Division or Vital Records, P.O. Box 68/60, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transh	Completed t	Coronaux ar-	leny disease		24a. Wa	as an 24b. Were a prior to death?	autopsy findings available completion of cause of
Vital sician: certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ☐ ER/Outp	Ouham	e of Death Check onl	one esidence 6 □Other (Sp	ecify)
vision or Vital Red Attending Physician: The lax ardeath. rector: After this certificate has by the funeral director, page 2	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Ti		28d. Describ	e how injury occurred	
Division or fo the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office		n (Street and Number or I Town, State)	Rural Route Number,
Dir To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the time, date a or investigation, in my opinion, de	nd place, and due to t ath occurred at the tin	he cause(s) and manner and deep date and place, and de	as stated. ue to the cause(s)
To the vithin To the comple	Me	29b. Signature and title of certifier Sahar Kohan	im, mD	29c. License number		April a7	nth, Day, Year)
10.41		30 Name and address of person who o	ompleted cause of death (Item 23a) (T	3001 S. Hanover	St, Baltiv	NOTE, MID	21225
	tate	31. Date filed (Month, Dev Dear)	2008 32. Regetrar's Signature	how.			
Regis			A state of	Marie			•

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BESSIE MARRIAN HILTZ APRIL 24. 2008 13:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Py, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 ☐ M 2 💢 F Director 212**-**18-9001 1913 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 No Maryland Harford Bel Air Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 608 Churchill Road 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. or, 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Dry Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Elmer Owen Benny Bessie Merriam Phelps 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Bachmann / Grandaughter Watervale Road, Fallston, Maryland 21047 PRIL 24,

Baltimore, 2060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Eremation 3 ☐ Removal from State Hilltop Service Corp. 4-25-08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

Annoximate 21. Signature of Funeral Service Licensee & (uss ry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic bowe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): physician a Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown CHE Completed Dm 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?/ Yes 2 No or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar DHMH 17 Rev 1/2001

State

BE5516

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 Month April Year **Physician** 25. 7:07 Ам Evelyn Joyce Higgins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville Montgomary If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 10 5. Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year Hours Min. 1 □ M 2 🗓 F 92 162-05-3178 Feb. 1916 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. xther than "natural", or Items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the McAlcal Exa, it has not be not the sal 1 □ Yes 2 No Director Maryland Montgomery Rockville 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 13607 Grenoble Drive 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 is marked other tha any injury or other traumatic event, Inal once. 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mahlon A. Faust Verna G. Blatt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carlton I. Higgins/Husband 13607 Grenoble Drive, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State April 29, Rockville, Maryland 4 □ Donation 5 ☑ Other (Specify)Entombment 2008 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville Inc. 300 West Montgomery Avenue Rockville, Maryland 21. Signature of Funeral Service Licensee John File M01360 20850-2805 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Heart Disease /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Parkinson's Disease Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dementia 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 🛛 No the 9 Unknown 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performed? /es 2X No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 24 hours after death Prineral Director: filled in by the 6 □ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 25, 2008 D0047330 Worms 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 W. Edmonston Dr., #207, Rockville, Maryland 20852-1290 Thomas V. Joseph, M.D.,

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Virginia L. Hasenei April 2008 1:40 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 6. Sex 1 □ M 2 😿 F 87 214-24-8344 Feb. 13, 1921 New York Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits 1 Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 434 Girard Street, Apt. #203 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21☑ No Specify. 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles McKay Martha Earlman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 434 Girard Street, #203, Gaithersburg, MD 20877 Diana H. Dalrymple / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 ☑Other (Specify) Entombment May 2, 2008 Woodlawn Cemetery Baltimore, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service Licen M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Longestive heart facture Lacks Due to (or as a consequence of): Due to (s a consequence of): Sequentiary het so remore, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown alliactheritie 24a. Was an 24b. Were autopsy findings available

Physician /Medical Examiner

Physician

/Medical

10a. State

Examiner

Funeral

Director

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Important: If item 27 is
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Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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certificate be exec

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

Examine Physician/Medical Completed by page 2 certificate director, Be r this Certification: After death. within 24 hours after death

To the Funeral Director:
completely filled in by the

in the past 12 months? 1☐ Yes 2☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chromeatrial telicital Cardione 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 ☐ Pending investigat 1 🗹 Natural 2 Accident 6 Could not 3 ☐ Suicide 4 Homicide

29d. Date signed (Month, Day, Year)

2008

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red to medical	F 0		26. Place of Dea	th (Check only one)	
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h 5 Pending investigation		28b. Time of 28 Injury M	8c. Injury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe how injury	occurred
6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory	, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	ysician: To the best of my kno niner: On the basis of examina and manner stated				and manner as stated. place, and due to the cause(s)

29c. License number

DOULIS

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ RUSSLL AUSULE (14. ROBSET BIRSCHBACIT, NUS. GAITHERSBURG, WID 20877 BIRSCHBACH INC.

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Charles Frederick Hieber 22-2008 9:28P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 4318 Falls Park Road Perry Hall Balto. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 ☐ M 2 ☐ F 220-42-9920 64 9-18-1943 Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Balto. Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4318 Falls Park Road 21128 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐Yes 2X No Specify: White Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Administrator Balto. Co. Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Ferdinand Hieber Edna Gertrude Rauch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patricia Hieber</u> 4318 Falls Park Rd. Perry Hall, Md. 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 4-26-2008 Timonium Md. 21. Signature of Funeral Service Licenses Schimunek Funeral Home 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final . Meta disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy nt pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy months? Month Day Year 5 ☐ Other (specify) 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygin Important: If Item 27 is marked other i any injury or other traumatic event, III

Physician

Examiner

Funeral

Director

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72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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and burial-tran attending physician nse for signed I page 2 should has certificate director. this After

Physician; The law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

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Examiner

Physician/Medical

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5 ☐ esidence 6 ☐ Other (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner' 1 | Yes 2 | ■ Mo 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be determined

Other: 4 \(\sum \) Nursing Home 28b. Time of 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

perform

1 □Yes

26. Place of Death (Check only one)

2 1No

29a. Certifier (Check only

1 Natural 2 Accident

3 Suicide

4 ☐ Homicide

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 0 6

29d. Date signed (Month, Day, Year)

State Registra

31. Date filed (Month, Day, Year) APR 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARLES SIR . Registrar's Signature

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036	be filed within 72 hours after death with the Maryland Hylgiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ▼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 IXYes, Give Year or Dates:		S. 13	. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14. Ra Bla Specii	ce - Americar ack, White, etc Wh		
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ë	and 2 st lealth an m 27 is r her traur		19a. Informant's Name/Relationship Carolyn Ann Hip				ling Address <i>(Street</i> 09 Forge V					*	
w	of Figer		20a. Method of Disposition **Disposition 3 **Disposition 3		20b. P		position (Name of ematory or other place		Date	20c. Location			
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F	Physician		23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that caused ly one cuse on each li	the death						A	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	a. Due to (or as	a consequ	uence of):					- u		
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o as	a conse	nce of):					y	ears	_
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.O. DOX	to the rospinal or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	☐ Ectopic pregnanc	у			ate of delivery	/ ay Year	
r v	w requires that the de been signed by the should be detached	by Pr	Part II. Other significant conditions	and the second second	\sim		1 0	en in Part I.	23e. Did to	bacco use con	tribute to the	cause of death?	
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ב ב ב	Physician: The law rthis certificate has t ral director, page 2 s	Completed								sy med?	prior to comp death?	y findings availal pletion of cause of	ole of
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5 6	iding Phy th. After thi funeral o	on: To	27. Manner of Death 1 ★Natural 5 Pending	28a. Date of Inju (Month, Da	rv	28b. Time Injury	of 28c. Injur		28d. Describe h		() //		_
2	death.	ficati	2 Accident investigat 3 Suicide 6 Could not	be See Blood of Init	Inv - At ho	me farm s	M 1 □	Yes 2 □No	28f. Location (S	Street and Numi	her or Rural I	Pouto Number	
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	lo the hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tr	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examinat	wledge, dea tion and/or	ath occurred at the tin investigation, in my o	me, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) and m date and place,	anner as state and due to the	ted. ne cause(s)	
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DHMH 17 Rev 1/2001

For State Registrar amend #13 Per FH G878 4/30/Objectificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1:15 AM M April 26, 2008 Leotis Johnson, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1651 Kingsway Rd. Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/12/1932 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min Hours Months 15 M 2 F MD 429-62-3274 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ir than "naturel", or items 23a or 28e-f show the Medical Examinar must be notified at 11⊈Yes 2 No MD Baltimore City Baltimore Direct with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 1651 Kingsway Rd. USA within 72 hours after death Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. t Syes 2 No If Yes, Give Year or Dates: 1951-1954 1 Never Married 28 Married Maryland 21215-0036 Yes 2XXIo Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Manufacturing College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Machine Operator ith and Mental Hygie 27 is marked other freumatic event, filed marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Dan Columbus Johnson Mary Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Importent: If Item 27 is
any injury or other tree Mary Johnson/Wife 1651 Kingsway Rd. Baltimore, MD 21218 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Apr 30 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2008 Chesapeake Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01443 22 Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland dynder She 23a. Part1. Enter the disease, or complications that caused the death. Do not inter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e cause on e cause on e Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 90015 a no rech **Physician** /Medical Due to (or as a consequence of). Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and is the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) 68760, Physiclan/Medlcal 35 the attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by t d be detact The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 : has autopsy certificate 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ŧ 2 1 Tes this in by the funeral 28b. Time of 28d, Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: within 24 hours after death. To the Funeral Diractor: After Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Mogth Day, Year) 29c. License number 29b. Signatur and title of cert Name and address of person who completed

State Registrar

31. Date filed (Month, Day, Year) APR 3 0 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Apr49¹¹26, 2008 Edith Jones 5:55 P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Multi Medical Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth July 12, 1916 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland Hours Months Days 220-14-9414 1 M 2 KF 91 Director Usual Residence of Decedent 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County N/A3 Maryland Baltimore 1 X Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3612 Eastwood Drive 21206 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. White þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Meinert Laura Riggins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine R. Jones-Daughter 3612 Eastwood Avenue Baltimore Maryland 21206 20b. Place of Disposition (Name of cametery, cramatory or other place) Gardens of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-30-08 Baltimore Maryland .22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service Licenspe husku 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Srage dementie Physician and disease or condition resulting in death) ear /Medical Due to (or as a consequence of): Examiner Acheroscher Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months Day Year signed by the at d be detached for 4□Pregnant at time of death 5 Other (specify) 1 □ Yes 2 🖬 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has performed 1 Yes 2 ☑ 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification:

K pue the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate is completely filled in by the funeral director, page

Baltimore, Maryland 21215-0036

A Natural

2 Accident

3□ Suicide

29a. Certifier

Medical

State Registrar

4 ☐ Homicide

5 Pending investigation

6 Could not be

(Month, Day Year)

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Sentiago Rd Suite MOZIC

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number 00053150 29d. Date signed (Month, Day, Year) APRIL 28 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature Shakunmale

Spente MD

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

08-03215 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Martin Jenkins State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day April 26, 2008 Medical Examiner Martin David Jenkins 0542 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) Director Months Davs Foreian 218-92-3316 Country)Maryland 1 x M 2 44 1963 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits Maryland Baltimore Baltimore 1 Yes 2 X No be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1016 Stormont Circle 21227 USA Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes 2 X No 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yss. Give Year à Snecify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HVAC Self Employed permit. Pages I and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked othe injury or other traumatic event, the N 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Vernard Be James Jenkins Barbara Marie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather L. Jenkins (Wife) 1016 Stormont Circle, Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Loudon Park Cemetery 5/2/08 Baltimore, Maryland 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Atherosclerotic cardiovascular disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ending physician a use as the burial -X AMENDED, 27, perME, g879, UNPENDED 5/6/08 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate has performed? 1 🗸 Yes Yes 2 2 No 25. Was case referred to medical director, 26.Place of Death (Check only one) Be examiner? Other₄ After this 1 🗸 Yes Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: ٩ No Il Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred X Natural death. Pending 1 Yes 2 No 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined To the Funeral (Specify) Homicide 29a. Certifier 1

Year

29d. Date signed (Month, Day, Year)

April 26, 2008

State

completely

Medical

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifie

Carol Allan, MD

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

Assistant Medical Examiner

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Physicia I Examir		For State	Certifica	te of D)eath	Menta		Reg. 1	do		
	n/11	egistrar . Decedent's Name (First, Middle,Last)	Ochinoa	10 0/ 2			Mo	e of Death	v Year		Time of Death
	er	William Klugel		- 1:	City, Town, or I	ocation of F	Apr	ii 21, 200	8 4c. County of		17541113
	4	a. Facility Name (if not institution, give stree 121 North Highland Avenue	t and number)		City, Town, or t	Cocation of L)cau		ior dodani, or		
Funeral		. Social Security Number 6. Sex	7. Age (In yrs. last birth	day)	If Under 1 Year				MM/DD/YYYY)	9. Birthpl Foreign	ace (State or
Director		215.32.1612 18M	2 F 73	Yrs.	Months Days	Hours	Min. 02	2.20.1	1935	Countr	y) MD
		Isual Residence of Decedent	10c. City, Town o	r Location						10	d. Inside City Limits
w any		0a. State 10b. County	Baltin							1	Yes 2 No
Aaryland 28a-f show 1 at once.	황	MD N/A	Daiti		10f, Zip Code			10g.	Citizen of Wh	at Country	?
he Mar 1 or 28 iffed a	Director	121 N. Highland	Avenue		21224				.S.A.		
with t ms 23s		1. Mantal Status 12.	Was Decedent Ever in U.S.	13. Was If Yes	Decedent of His , specify Cuban	panic Origin , Mexican, F	n? (Specify Puerto Ricar	Yes or No- i, etc.)	14. Race White		Indian, Black,
r death	Fun	1 Never Married 2 Married 1	Yes 2 No		′es 2 No				Specify:	Wh	ite
rs after ural",	d b	Widowed 4 Divorced If Yes or Div	host grade completed) 16a [Decedent's	Usual Occupat	tion (Give ki	nd of work d	one 1	6b. Kind of Bu		ustry
72 hou n "nat	etec	Elementary/Secondary (0-12)	College (1-4 or 5+)	aint	ot of working life	. DO NOT u	se remed)	1	Gener		
within er tha	Complete	12				18.Mother's	Name (Firs	t, Middle, Ma	iden Surname		
Baltimore, MD 21215-0036 permit: Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (First, Middle, Last) unknown unk	nown			Haz	el El	lizab	eth Ko	ber	
212 212 213 214 215 215 215 215 215 215 215 215 215 215		19a. Informant's Name/Relationship (Type,	Print) 19t		Address (Stree						
MD d 2 sho Ith and n 27 is aumat		Carolyn Stack/Si 20a. Method of Disposition			Edgew ion (Name of ce		Ave	e, ba	20c. Location	- City or To	MD 21237 own, State
of Hear Ir iter		20a. Method of Disposition 1 Burial 2 Cremation 3 R	emoval from State cremat	ory or other		1	04 1	28 08	Rolts	.vi1	le, MD
ti Page tment trant: 7 or ot	ļ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee									nrmann,
Bal permi Depar Impo injur	1	D. 1 D. R.1	HO1443	ΙP.	A. 871	l7 Gr	een 1	astu	res Dr	. B	alto., N
P hysician		23a. Part Enter the disease, or complicating failure. List only one cause on each line.	ons that caused the death. Do no	ot enter th	e mode of dying	, such as ca	ardiac or res	piratory arres	st, shock, or he	eart	Approximate Interview Between Onset an Death
Medical xaminer		Immediate Cause (Final disease a. At	nerosclerotic cardi	iovasc	ular dise	ase		-		- 1	Death
_Kuiiiiioi		or condition resulting in death) Due	to (or as a consequence of):								
	er		to (or as a consequence of):								
,	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):								
recuted and ransit	ш	d									
oe execician a	dica	X UNPENDED	ZSa,27, perMEG879,	5/6/08	TT				23d. Date of	of delivery	
the Ilospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Athours after death. The Tuneral Director: After this certificate has been signed by the attending physician and the Planeral Director. Appending physician and pheley filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/Medical	23b. Was decedent pregnant in the	3c. If yes, outcome of pregnancy Live birth		tal death 3	Ectopic	c pregnancy		Month		ay Year
OX 68' eath certifi	iciai	past 12 months?	Pregnant at time of death		ner (Specify)						
Bo he deat the deat hed for	≨ا		Unknown	na in the u	inderlying cause	given in Pa	art I.	23e. Did to	bacco use con	tribute to t	he cause of death?
of Vital Records, P.O. Bing Physician: The law requires that the dAfter this certificate has been signed by the funeral director, page 2 should be detached	by	Part II. Other Significant Conditions	in both g to both but he had a					1 Yes	2 No :	3 Prob	abiy 4 🗹 Unknov
ds, equire een sig ould b	Completed							24a. Was a		prior to c	opsy findings availa ompletion of cause
e faw re has b	直							perfor		death? 1 ✓ Ye	s 2 No
Division of Vital Records, pital or Attending Physician: The law requir ours after death. reral Direct. After this certificate has been stiffled in by the funeral director, page 2 should it	ပ္စိ	25. Was case referred to medical			26.Pla	120	(Check only				
Vita ysicia this ce	B O	examiner? 1 ✓ Yes 2 No	1	Outpatient		Other ₄	Nursing H		Residence 6		: Scene
of ing Ph After funeral	=	27. Manner of Death 1	28a. Date of Injury (Month, Day,Year)	. Time of		njury at Worl	_ I	u. Describe i	low injury cook		
Sion Attendi death.] ₩	2 Accident Investigation	28e. Place of Injury - At home,	farm, stre						nber or Ru	ral Route Number,
Division tal or Attendir rs after death. 'al Director: △	Certification:	3 Suicide 6 Could not be determined	(Specify)					or Town, S	itate)		
Tospite 4 hour		29a. Certifier 1 Certifying Physician:	To the best of my knowledge, d	leath occu	rred at the time,	, date and p	lace, and du	e to the caus	e(s) and man	ner as stat	ed.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner:O	To the best of my knowledge, on the basis of examination and/ondigeneous tated.	r investiga	ition, in my opin	ion, death o	ccurred at tr	ne time, date	and place, and		nth, Day, Year)
E S E S	×	29b. Signature and title of certifier	1			ense number C.M.E.	1		April 22,		, 20,, 1001)
DE PO	-	Tanthis suthall is	171)			J. (VI. L.	 				
1300mm	1	30. Name and address of person who con Pamela E. Southall, MD	npleted cause of death (Item 23a Assistant Medical Examir	ner 1	11 Penn Str	eet, Baltii	more, ME	21201			
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signature		هـ - ف						
			08 Brown A	2	DEALL						
Regi	J. ()		0				-		UCIVIE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 915 **Physician** Madeleine N. Kyle /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Lanham Doctor's Community Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 88 Berkeley Springs 219-01-4547 Oct 6, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County fshow r 28a-f show notified at 1K Yes 2 No Bowie Maryland Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be 20720 USA 13905 Old Stage Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 X No Specify Baltimore, Maryland 21215-0036 Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 12 Elementary/Secondary (0-12) Cemetery Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in ment of Health and Mental Margaret Fox ၉ Filmore Norris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 shu Department of Health and Important: If Item 27 Is m any injury or other traum 13905 Old Stage Road, Bowie, MD John Burns - Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Brentwood, Maryland 5/3/2008 Fort Lincoln Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Lews P. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASPIRATION Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** ENEBROUMSULAR Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner PTI the attending physician and the for use as the burial-tran death certificate be exec P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🔼 No 4☐Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ pe 1 Yes 2 No 3 Probably 4 Wakhown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? 2 No certificate 1 🗆 21 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DER/Outpatient 3□ DOA 1 ☐ Yes 2 LN 1 Inpatient ဥ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Injury 5 ☐ Pending 1 Yes 2 No Investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide to the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

HANOVER PARKWAY

32 Registrar's Signature

Greenbelt, Md 20770

C. Donald George MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7500

IOIA

31. Date filed (Month, Day, Year) APR 3 0 2008

Suite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AFIND TIPM 20d per PIVS 0878 4 3078 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 04-10-2008 Joan Kozel 2327 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Hospital Bel Air If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Months 1 □ M 217 F 215-32-8459 71 10-05-1936 Maryland Director Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2 No Director Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 USA 1305 Winding Valley Drive "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baftimoke, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " any Injury or other traumatic event: the Mea Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Schmidt Anne Moltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1305 Winding Valley Dr Joppa, MD 21085 (Husband) Frank Kozel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04-14-08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Figneral Service Linesee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it may be any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of) Examine burial-transi C Due to (or as a consequence of) Loze Joan MSCO41340) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No 27. Manner of Seath Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month 2008 ar) 29c. License number 29b. Signature and title of certifier 00063220 GEORGE ISCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 3 0 2008 Registrar

DHMH 17 Rev 1/2001

State

Registrar

Name and address of pe

APR 3 0

2008

ho completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03218 State of Maryland / Department of Health and Mental Hygiene Ronald Paul Leftwich Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day April 26, 2008 0830 hrs **Medical Examiner** Ronald Paul Leftwich c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Brentwood 3707 Upshur Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year if Under 24Hrs. 6. Sex 5. Social Security Number reign Country) Washington **Funeral** oreign Months Days Min Hours Director 8/20/1949 1 X M 2 F 58 213-56-4796 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 X Yes 2 No Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygene.
Important: If iten 27 is marked other than "natural", or items 23a or 28a-f show
injury or other transmatic event, the Medical Examiner must be notified at once. Prince George's Brentwood Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 20722 3707 Upshur Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 X Yes 2 No Specify: Yes 2 X No specify: White Divorced Give Year Vietnam Widowed ⋧ 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fire Arms Sales Clerk 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Marie Herath William Frank Leftwich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٥ 3707 Upshur St., Brentwood, MD 20722 Louise Nelda Leftwich, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4/30/08 Alexandria, VA Metropolitan Crematory 4 Donation 5 Other Specify: 22. Name and Address of Facility 4739 Baltimore Ave. 21. Signature of Funeral Service Licensee Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part I. Enter the disease, or Compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death /Medical Hypertensive cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED physician a AM#255,27,perME,g879 5/21/08 TI 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year by the attending pached for use as the Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? certificate has 2 No Yes 2 No 1 🗸 Yes Hospital or Attending Physician: The hours after death. Funeral Director: After this certificately filled in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other:

Nursing Home 5 Residence 6 Other: Scene examiner? Hospitat: 1 Inpatient 2 DDA ER/Outpatient 3 ဥ 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide within 24 hours a determined the Hospital 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 dical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifie

Margarita Korell MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Fegistrar's Signatur

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 27, 2008

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D43202

29c. License number

29d. Date signed (Month, Day, Year)

April 28, 2008

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director:

> Jack Titus MD. 31, Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

and manner stated

Deputy Chief Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 21, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April 27, 2008 4c. County of Death 7:45 PM /Medical Joseph Francis Murrill, Sr. 4a. Facility Name (If not institution, give street and number) **Examiner** Long Green Center - Genesis Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1**2** M 2□ F 72 Director 05/02/1935 MD 216-30-7522 Usual Residence of Decede filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore City Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 14. Race - American Indian, 21215 Funeral 2617 Park Heights Terr. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Black 1952-1979 Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Corrections Facility Elementary/Secondary (0-12) College (1-4or 5+) Corrections Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Walker ဥ Clarence Murrill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2122 Saint Paul Street Baltimore, MD 21218 Duane Murrill/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Apr 30 Chesapeake Crematory Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Fa M01443 Cremation and Funeral Alternatives
8717 Green Pastures Drive Baltimore, Maryland
1 proximate Introval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 YEAR LUNG **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examiner be executed and burial-trai Due to (or as a consequence of) Box 68760. physician Physician/Medical requires that the death certificate the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 DEctopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 ☐ Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s certificate has 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient this 28b. Time of 28d. Describe how injury occurred funeral 28a Date of Injury 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the 27. Manner of Death Certification: After t (Month, Day Year) Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

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within 2.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

APR 3 0

mo 32. Registrar's Signature KILBRIDE RD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1- State Registrar Amend #8 per INF, G880 6/9/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 8:06 PM Shawnita A. Mitchell APRIL 27 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE CITY HOSPITAL OF BACTIMORE SINAI If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 1/20/19819, Birthplace (State or Foreign Months | Days | Hours | Min. | (Month, Day, Year) | Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 🔀 F Director 218-04-4492 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at ¥FIYes 2 □ No Director MD n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 <u>USA</u> 4001 Eldorado Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: African American 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) 911 Operator permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other transment. Baltimore City Police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jerry Mitchell Lavenia Pollard ပ္ EXT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lavenia Pollard-Mother 4001 Eldorado Avenue, Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 3 Removal from State King Memorial Park 5-2-08 Woodlawn, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral/Service License andone 9200 Liberty Road, Randallstown, MD 21133 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** DISSEMINATED INTRIASCULAR COAGULATION DAY /Medical Due to (or as a consequence of): Examiner MRSA DAY SEPTICEMI Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 □Unknown END-STAGE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient P 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation s after dea...
seral Director; A'
filled in by the 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide ō Hospital To the Hospital within 24 hours a To the Funeral C 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier APRIL 27, 2008 RFS OUT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SENGUPTA

DHMH 17 Rev 1/2001

State Registrar SOM A

31. Date filed (Month, Day, Year) APR 3 0 2008

HOSPITAL

OF BALTIMORE

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MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** Christine Renee Mackel April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under If Unde Hours 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months 55 Director Apr. 29, 1952 212-60-3303 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County la or 28a-f show t be notified at 1 ☐ Yes 2 ▼No Director Randallstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3947 Brice Run Road USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specifo African-American or) Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Claims Representative Social Security Admin. Department of Health and Mental Hygie Important: If Item 27 is marked other t any injury or other traumatic event, th (nce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Nathaniel Mackel Sr. Mildred Connaway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Jones/Mother 9415 Tulsmere Road, Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 5-2-08 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A.of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): 24 hours Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2∏ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 2 No 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 DOA 2 27. Manner of Death 28a Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29a. Certifier Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funera

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of exifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tansen

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D5434

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia /Medic		Registrar 1. Decedent's Name (First, Middle, Las	State of Maryl 33a, PtII,				2. Date of Dea	ath		3. Time of D	Death
/Medic		Selena F	·				Month 04	16	2008	12:00	P
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. C	ounty of Death	1	
Lxaiiiii	CI	Bethesda Health	Care Center		BEthes	da		M	ontgome		
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ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13. 1	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spon. Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14	1. Race - Amer Black, White		
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State of Maryland / Department of Health and Mental Hygiene []

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Haze1 Trimbach Moore 2008 April 4:45a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7200 Third Avenue Carroll Sykesville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 □ F 411-16-5554 1918 Georgia Dec Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene. That use 23 a or 28a-f show ant; if item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Exeminer must be notified at uny or other traumatic event, the Medical Exeminer must be notified at 1√ Yes 2 No MD Carroll Sykesville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7200 Third Avenue C - 6121784 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: white 3 TWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Xavier Trimbach Hazel Falks 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carol A. Moore (daughter) 7246 Dockside Ln., Columbia, MD 21045 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5-2-08 Perryman, MD St. George Cemetery 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daugh Hough sterber P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ng physician and as the burial-transit Due to (or as a consequence of): IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear in the past 12 months? ō 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknowr 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available 2 Be ² 2

Division or Vital Records, P.O. Box 68760,

Certification: Medical

autopsy prior to completion of cause of death? 1 Yes 2 No
26. Place of Death (Check only one)
Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury at Work? 1 □ Yes 2 □ No
office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
the time date and place and due to the cause(e) and manner as stated
the time, date and place, and due to the cause(s) and manner as stated. n my opinion, death occurred at the time, date and place, and due to the cause(s)
at

and title of certifier 29b. Signatu

Westminster MD 21158

State Registrar

31. Date filed (Month, Day, Year) APR 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician 24 2008 1ax ohn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year If Under 24 Hrs. NION morla Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Country **Funeral** Months Hours Min. 1 M 2 □ F 83 Yrs. 228-22-5456 4 118/25 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 14 Yes 2 No Ba NA Himore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 ralls Completed by Funeral 12. Was Decedent Ever in U.S. Armed orces? 1 Dres 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☑ No Maryland 21215-0036 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem aborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUCY BridgeforTh Max ပ Ihomas 19b. Mailing Address (Street and Number or Rulal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. P. (Son) Avenue 33/3 St Ambrose Thomas May MO 21215 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/08 Baltimore Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address o acility 255 2222 W. North 21. Signature of Funeral Service Licensee Travis L. M. Tatelle , MD 21216 · North Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumothorax One month Physician /Medical Due to (or as a consequence of): Twenty years Examiner Obstructive Aronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes P.O. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? certificate has 怄 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Physician: Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient this 28d. Describe how injury occurred funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After the Certification: After t Injury (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D00631 CARCET wachinemere, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East Univerysity wachinemer, M.D.

3x Year) 2008 32 Registrar's Signary State

DHMH 17 Rev 1/2001

Registrar

Bernice Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mazan State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 04-24-2008 Bernice M. Mazan 0841 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 306 Canterbury Rd #K Harford Bel Air If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 70 01-10-1938 Maryland Director 212-36-4176 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ul Hygiene. other than "naturel", or items 23a or 28a-f ehow vent, Ita Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Canterbury Rd #K 21014 deeth Completed by Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Admin. Asst. Insurance Ith and Mentel Hygin 27 is marked other r treumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Alexander Klosek Bessie Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 :
Depertment of Heelth ar
Important: If Item 27 is
eny injury or other treu Brian Mazan (Son) 613 Kilmarnock Tr. Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 04-28-2008 Fallston, MD Highview Mem. Gar. 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed inding physicien and use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) signed by the e P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown my 0/9/6 Completed

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within 24 hours at To the Funerel Di completely filled in Hospital

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Medical

24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No t TYes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 DoNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred t Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

29a.	Certifie	١
	(Check	or
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1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

Mail

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29d. Date signed (Month, Day, Year)

mel 21 M22 1814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 0510 AM Myers April 2008 26 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Burnie BALTIMOIR Washington Medium Coate Glen Anne Mounda 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 26 1923 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F Min. 217-16-5475 85 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits an "naturai", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8008 Tick Neck Road 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Salerno Rosa Lee Unknown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Depertment of Health ar important: If item 27 is any injury or other trau 8008 Tick Neck Road, Pasadena, MD 21122 Joyce Vernon (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 30 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 2008 <u>|Crownsville, Maryland</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the dilease, or comshock, or heart fail ire. List only tions the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, au win each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 14 CALT FAILUR Congestive /Medical Due to (of as a consequence of): **Examiner** MYOCANEM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or, sician and burial-transit Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 📉 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 **N**Vo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 26, 2008 0027415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Baltimore Washington Medical Center FRANCIS

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 3 0 2008

32. Registrar's Signature

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(JOSEPH DANIEL 4a. Facility Name (if not	institution, giv	e street and nun	nber)		4b. C	ity, Town, or I	Location of D		· ·		unty of Deat	h
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Funeral	4	5. Social Security Number			7. Age (in	yrs. last t	oirthday) If	Under 1 Year	If Under 2	24Hrs.	8. Date of Bir	th (MM/DD/	YYYY) g. Bir	rthplace (State or Foreign buntry)
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5-0036 lted within 72 hours after Hygiene. I other than "natural", the Medical Examiner	Ŝ	17. Father's Name (Firs	t, Middle, Lasi	t)							First, Middle,	Maiden Sur	name)	
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Records, P.O. Box The law requires that the death cate has been signed by the atto page 2 should be detached for u		Part II. Other significa	nt conditions	s contributing t	to death bu	ut not res	ulting in the und	erlying cause	given in Pa	rt I.				to the cause of death? Probably 4 Unknown
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Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death. Funeral Director; After this certificate has been si tely filled in by the funeral director, page 2 should b	<u>ا:</u>	27. Manner of Death	140	28a. Date	e of Injury		28b. Time of Inju	ry 28c. Inj	jury at Work	?	28d. Describ Driver aut			
ondin ath. he fur	늘	1 Natural 5			th Day Year , 2008	´	1155 hrs	1	Yes 2 🗸	No				
riSic r Atte ter de irecte n by t	<u>ප</u>	2 Accident 3 Suicide 6	Investig Could n	28e Pla	ce of Injury	y - At hon	ne, farm, street,	factory, office	building, et		or Town	State		Rural Route Number, City
Div italo urs afi Iled i	Certification:	4 Homicide	determin) Major	r Road	/ Highway				Rt. 10 Sout	hbound @	Rt. 648 , I	Harundale , MD
Hosp 24 ho Fune tely fi		29a. Certifier 1 Ce	rtifying Phys	ician: To the be	est of my k	nowledge	e, death occurre	d at the time,	date and pla	ace, and	due to the ca	use(s) and	manner as s	stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Me	edical Examir	ner:On the basis and manner	of examir stated.	nation and	d/or investigation			curred a	e ume, da			
F 8 F 8	N N	29b. Signature and titl	e of certifier	110	U 0	0 -	1 .	l l	nse number			i		(Month, Day,Year)
		Carr	ore	Ne		XU		_ 0.0	C.M.E.			April	26, 2008	
h		30. Name and address					23a)			0400	4			
')		Carol Allan, M	ID Assis	stant Medica	15.5		111 Penn St	reet, Baltir	more, MD	∠120				
Pagis	tate		Day, Year)	- A	egistrar's	Signatur	e Anse	Se s						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year APRIL 5:40 AM HELENA 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death MANOR CARE TOWSON BALTIMORE RUXTUN If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Date of Birth (Month, Day, Ye 1/12/20 9. Birthplace (State or Foreign Country)
Scotland 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 1 F 131-05-2237 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2508 Linwood Rd. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wallace Henrietta McCallum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Newman / 2508 Linwood Rd. Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 05/08/08 Bushnell, Flordia 4 ☐ Donation 5 ☐ Other (Specify) National Cemetery 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service LicerSee 3620 Wilkens Ave. Baltimore, Maryland 21229 locations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List on PEMENTIA Immediate Cause (Final disease or condition resulting in death) ALZHEIMERS Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Many injury or other traumatic event injury injury or other traumatic event injury injury or other traumatic event injury injury injury injury or other traumatic event injury injury

Physician

/Medical

Examiner

10a. State

Funeral

Director

a or 28a-f show be notified at

"natural", or items 23a edical Examiner must b

Director

Funeral

þ

Completed

Be

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit been signed by the should be detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

P.0.

Division or Vital Records,

Examiner Physician/Medical þ Completed မ Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

28d. Describe how injury occurred

24a. Was an autopsy perform 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

	1 ☐ Yes	2 ₩ N	0
27.	Manner of	Death	
	1 Natura	al	5 Per
	O A coid	net.	inve

29a. Certifier

25. Was case referred to medical examiner?

nding estigation 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little Certific

29c. License number M.D. 057722

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 2008 APRIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TREE ROAD #300 PIKESVILLE MD 21208 LEUNARD PICHARDSON 1838 GREENE

State Registrar

Medical

32. Rigistrar's Signature 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	Olato of Mil	, ,		tificate of L	Death	Re	g. No.	14001
Ī		_	1. Decedent's Name (First, Middle,	Last)		-			Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	_	Yuriy V. 01	yshko					4-28-20	008	4:40A M
	Examin		4a. Facility Name (If not institution,					Location of Death		4c. County of Dea	th
-200			3 Fernsell Ct.				Roseda	ILE If Under 24 Hrs.	8. Date of Birth	Balto.	thplace (State or Foreign
	Funeral Director		215-63-3634	i. Sex 7. Ag 1X M 2 □ F	e (In yrs. la.	Yrs.	Months Days	Hours Min.	3-4-195	Year) Co	aine
70	www.		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				10d. Inside City Limits
Annah	f sho	ō				Po	sedale				1 ☐ Yes 2 ☐ No
4	28a-	Director	Md . Ball	.to.		RO	10f. Zip Code		10	g. Citizen of What Co	ountry?
4	3a or	O E	3 Fernsell Ct	. Apt.3C			2123	37		Russia	L
100	ms 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		. 13. V	Was Decedent of H	ispanic Origin? (Sp nn, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	
5-0036	illed within 72 hours after obain wift from Maryano Hygiene, than "natural", or items 23a or 28a-f show with than "natural", or items 23a or 28a-f show ant, the Madical Evantine Listat be notified at	þ	1 ☐ Never Married XX Marrie 3 ☐ Widowed 4 ☐ Divorced		No		I∐Yes 2 X No	Specify:	,	Specify:	White
2-0	natur fical	sted	15. Decedent's	Education grade completed)		(Give	dent's Usual Occup	during most of work		6b. Kind of Business	/Industry
7	nthin he. han "i	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	ilife. L	DO NOT use retired	1)		Church	
12	al Hygiel other th		17. Father's Name (First, Middle, L	anti		Pa	stor	18. Mother's Name	e (First, Middle, M		
anc	eve eve	Be	Vladimir Olyshl		ather			Mariya	, , , , , , , , , , , , , , , , , , , ,		
Maryland	ges 1 and 2 should be filed to f Health and Mental Hyg If item 27 is marked other or other traumatic event, I	<u>۵</u>	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street		ral Route Number,	City or Town, State,	Zip Code)
	nd 2 salth ar		Natalya Olyshko	Wife						1e, Md. 21	
ب <u>آ</u>	es 1 and 2 of Health Fitem 27 i		20a. Method of Disposition			ace of Dispo	sition (Name of natory or other place	ī I	Date 2	20c. Location - City of	Town, State
٤	Pages nent of ant; If its ary or o	ΙÌ	ty∏ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □ Removal from State ecify)		Highv			-2008	Fallsto	on
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service C	censee	- de	22	2. Name and Addre		1 11	0705 B-1-4	D.J
<u> </u>	89 = 9		Daret	noch						9705 Belai	
			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	omplications that cause only one cause on each l	d the death. ine.	Do not ent				est,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	_aM	stas	taTic	RENO	4 6	Cer		44 Eass
	/Medical Examiner	Ш	resulting in deathy	Due to (or as	a c'nsequ	ence of):					L
		ja	Sequentially list conditions,	b Due to (or as	a consequ	ence of):					
3	ansit ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
oʻ	an an rial-tr		resulting in death) Last	Due to (or as	a consequ	ence of):					
68760,	ricate be executed physician and street streets the burial-transit	Medical	1	d							
9	ertifica ling pl		IF FEMALE:								
Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant	2 🗌 Fetal	death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		23d. Date of d Month	elivery Day Year
0	res that the de signed by the a be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	at time of ut	eatti 5L					
σ.	that t		Part II. Other significant conditio	ns contributing to death	but not resu	Iting in the u	nderlying cause giv	en in Part 1.	23e. Did tol	pacco use contribute	to the cause of death?
Records,	puires n sign lld be	d by							1 □ Ye	es 2 X No 3 □ I	Probably 4 🗌 Unknown
000	w requir s been si should I	Completed							24a. Was a		autopsy findings available completion of cause of
ٍ ۾	The law ite has age 2 :	E O							autops perforr 1 □ Yes	ned? death?	es 2 \(\sigma \) No
<u>ta</u>	lan: artifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only on		
<u>}</u>	hysic his ce I direc	은	1 Yes 2 No				III 3LI DOA	ner: 4 Nursing H	_	ence 6 Other (Sp	necify)
בו	ing P	on:	27. Manner of Death 1 Natural 5 Pending		jury ay, Year)	28b. Time o Injury	Wor	ryat rk?]Yes 2.∐No	28d. Describe ho	ow injury occurred	
Sio	ttend death tor:	icat	Accident investig	ot be	niury » At ho	me farm st	reet, factory, office	ites Z Lino	28f. Location (Si	treet and Number or i	Rural Route Number,
Division of Vital	or A after Direc	Certification:	4 ☐ Homicide determi	building, e	tc. (Specify	")	,		City or Towi	n, State)	
_ [To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1 Certifyin	g Physician: To the bes	t of my kno	wledge, dea	th occurred at the t	ime, date and place	e, and due to the d	cause(s) and manner	as stated.
	n 24 h n 24 h ne Fu	edical	(Check only 2 Medical one)	Examiner: On the basis and manners	of examina	tion and/or II	nvestigation, in my	opinion, death occu			
	Voithi Comp	M	29b. Signature and the of certifier				29c. Licen	se number	2	29d Date signed (Mo.	nth, Day, Year)
			AA	4				U 5375	9	4pn/2	4,2008
	E		30. Name and address of person		death (Item			CL D	ih	MA	3 - 3 6 4
	<i>y</i>		31. Date fied (Month, Day, Year)	Cain Regis	trar's Signa	ture	DEON'S	21 /20	LITMORS	.5	21901
	St: Regist	ate rar	APR 3 0 7	2008 Regis	0 1	Sport	relie				

			_ FOF	/laryland / De	epartment o	Health and I	-	_	ible.	
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	(Certificate o	of Death	2. Date of De	Reg. No. 2	108	3. Time of Death
	Physicia		Crystal Pilker	T			Month	Day	Year	6:30P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number		4b. City, Tow	n, or Location of Deatl	April	25, 20 4c. Count	008 y of Death	
	Examin	iei	304 Oakwood Rd.	,				D-1		_
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birth			8. Date of Birt	th		place (State or Foreign
	Director		212-82-6482 1□M 3\(\vec{Q}\)F	44 Y	rs. Months Da	ys Hours Min.	(Month, Da)3/1963	MD	intry)
	pc ,		Usual Residence of Decedent	140 - 00 - T-			. 10/1	/3/1303		
	arylar show d at	_	10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f :	cto	MD Baltimore	Dunda						
	or 2	Director	10e. Street and Number		10f. Zip Coo	е		10g. Citizen of	intry?	
	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notifiled at	ra	304 Oakwood Rd.		212			USA		
	er de Item:	Funeral	11. Marital Status 12. Was Decede Armed Force	s?	If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	pecity Yes or No to Rican, etc.)	- 14. Ha Bla	ice - Amer ick, White	ican Indian, , etc.
0000	rs aft	by F	1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date		1 □ Yes 2 🗷	No Specify:		Speci		
⋛	tura tura	ed	15. Decedent's Education	16a. E	Decedent's Usual Oc			16b. Kind of E		ite ndustrv
2	in 72 n "na Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-44)	(Give kind of work do life. DO NOT use re	ne during most of wor tired)	rking	Own H		
7	with giene r tha	Completed	college (1-44		omemaker			Own II	Ome	
2	be filed within 72 tal Hygiene. d other than "nal event, the Medica	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle,	Maiden Surna	me)	
10	Ald by Aenta	To E	William Francis Pilkerton			Mary Alice Lesche				
Mal	2 should be filed within and Mental Hygiene. is marked other than raumatic event, the Me		19a. Informant's Name/Relationship (Type. Print)	19b. I	Mailing Address (Str	eet and Number or Ri	ural Route Numb	er, City or Towr	n, State, Z	ip Code)
_	is 1 and 2 should be filed within 72 hours after death with the Marylan of Hembar and Mental Hygiene with marked all Hygiene with them 21 is marked other than "natural"; or flems 23a or 28a-f show them 27 is marked other than "natural"; or flems traumatic event, the Medical Examiner must be notified at		Jeffrey Ward/companion	3	04 Oakwoo	d Rd. Dunc	dalk, MD	21222		
5	of He		20a. Method of Disposition 1 ☐ Burial 2 ★ remation 3 ☐ Removal from Sta	comotory	Disposition (Name o crematory or other	place)	Date	20c. Location	- City or 1	Γown, State
altillinor	Pag ment ant: I ury c		4 Donation 5 Other (Specify)		peake Cre	matory Inc	Apr 30 2.2008	Belts	ville	, Maryland
<u></u>	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licensee	401442	22. Name and Ad	Idress of Facility				
_	20 E 8 9		Lyda Sue Ritter	<u> </u>	8717 Gr	on and Fune een Pasture	s Drive	Baltimo		aryland 21286
			23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death. Do no i line.	ot enter the mode of	dying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
, 1	Physician		Immediate Cause (Final disease or condition	atic canc	20					Onset and Death
ŧ.	/Medical Examiner		resulting in death) Due to (or	as a consequence of	f):					
	Lxammer	_	Sequentially list conditions, b. Leon	ic failure	0.					
~	₩ / 1/65	ine	cause Enter Underlying	as a consequence of	1):					
	an and rial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or	as a consequence of	f):				-	
oC,	be e ician buria	1_		·						
0/00	phys phys s the	Physician/Medical	d							
XOO	certif ding se a	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco	me pf pregnancy				23d D	ate of deli	verv
ă	atter for u	ciar	in the past 12 months?	n 2 ☐ Fetal death t at time of death	3 ☐ Ectopic pregn 5 ☐ Other (specifi				fonth	Day Year
į.	the can the achec	Jysi	9 ☐ Unknown 9 ☐ Unknow	ר						
<u>,</u>	that hed b		Part II. Other significant conditions contributing to deat	n but not resulting in	the underlying cause	given in Part I.	23e. Did t	obacco use co	ntribute to	the cause of death?
2	quire; n sign	d by					1 🗆	Yes 2□ No	3 Pro	obably 4 Unknown
ecoras	w rec	Completed					24a. Was	an 24b	. Were au	topsy findings available
Ĕ	The la	E C						ormed?	death?	ompletion of cause of
VII.a	an:] tificat tor, p		25. Was case referred to medical			26. Place of De	1 Yes ath (Check only o	2 No	1 🗆 Yes	2 □ No
=	ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp	atient 2 ER/Outp	patient 3 DOA	Other:	Home 5 Resi		ther (Spec	cifv)
101	g Ph ier thi		27. Manner of Death 28a. Date of	njury 28b. Ti	ime of 28c.	Injury at Work?		how injury occu		
UNISION	ath. r: Aft	atio	2 Accident investigation	Day rear) III	, ,	1 ☐ Yes 2 ☐ No				
<u> </u>	r Atte	tific	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building	injury - At home, farr etc. (Specify)	m, street, factory, of	ice	28f. Location (Street and Nun wn, State)	nber or Ru	ıral Route Number,
5	tal or	Certification:		, , , , , , , , , , , , , , , , , , , ,				, 5.2,		
	t hour t hour uner		29a. Certifier 1 ☐ CertifyIng Physician: To the be 2 ☐ Medical Examiner: On the bas	est of my knowledge, s of examination and	death occurred at the	ne time, date and place my opinion, death occ	e, and due to the turred at the time	cause(s) and r	manner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be evaithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical	one) and manne	stated.			T			
	7 wit 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-	29b. Signature and title of certifier		29c. Li	cense number		29d. Date sign		
	9		(Schroudy M,		U	66077		04-	98	- 7008
	/		30. Name and address of person who completed cause	of death (Item 23a) (T	- 1	· -		110	110	L I
	~~	te.	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	Oslen Dr	ive, lov	, men	7-11) 7	120	ζ,
	Sta Registi		455 9 0 2000	la	A 10		-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		С	ertificate of L	Death			eg. No. 2	008	14089	_
т	Physicia		1. Decedent's Name (First, Middle, L					M	ate of Deat lonth	Day	Year	3. Time of Death	
	/Medic	al		kalides					pril		008 nty of Death	8:18 A M	4
	Examin	er	4a. Facility Name (If not institution, g			4b. City, Town, or		Death				_	
	4		27 Lakeside Driv 5. Social Security Number 6.	7e	ast birthd	Greenbe		4 Hrs. 8. Da	ate of Birth		9. Birthr	eorge's place (State or Foreign	\dashv
	Funeral Director		154-18-1995	X M 2□F 82	Yrs	Months Davs	Hours		Nonth, Day,	1925	Jerse	ey City, NJ	1
h	7	t	Usual Residence of Decedent										7
	nyland how		10a. State 10b. County	10c. City,								10d. Inside City Limits 1 X Yes 2 □ No	1
	e Ma 3a-f s tified	읂		George's Gr	eenb								_
	or 28	Directo	10e. Street and Number			10f. Zip Code	20770		1	0g. Citizen o	of What Coul	ntry?	Ì
	s 23a	<u>ra</u>	27 Lakeside Driv	12. Was Decedent Ever in U.S				in? (Specify)	es or No-	14. F	Race - Americ	can Indian,	\dashv
	item item	Funeral	 Marital Status Never Married 2 Married 	Armed Forces?	·	 Was Decedent of H If Yes, specify Cuba 	an, Mexican,	, Puerto Rican	i, etc.)	E	Black, White,	, etc.	
36	Irs aff	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give WWII Year or Dates:		1 ☐ Yes 21X No	Specify:			Spe	cify: W	Mite	
Š	be filed within 72 hours after death with fine Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's (Specify only highest of	Education	16a. De	ecedent's Usual Occup	ation during most	of working		16b. Kind of	f Business/In	ndustry	
21215-0036	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`In	fe. DO NOT use retired	d) -	ŭ		T7.1.			
2	ed wi ygien yer th	S		5+	F	dministrat		r's Name (Firs	at Middle		ıcatio	n	-
ng L	be fill	Be	17. Father's Name (First, Middle, La John Paskalides	St)				nnasta					
3	J Mer J Mer narke	유	19a. Informant's Name/Relationship	(Tuno Print)	19h M	ailing Address (Street						ip Code)	
Maryland	d 2 st th and 7 Is r traur		Barbara Ann Pask		111111111111111111111111111111111111111	Lakeside					20770		3
ص ر	Heal Heal tem 2	1	20a. Method of Disposition	20h Pl	lace of D	isposition (Name of crematory or other place	1	Date			on - City or T		Т
Baltimore,	permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 Is marked other th any Injury or other traumatic event, the		1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	LI Removal from State		litan Cremat		4/27/20	800	Alexa	ndria	, VA	
<u>=</u>	nit. F artmo ortan Injur		21. Signature of Funeral Service Lie			22. Name and Addre	ss of Facility	у		4739	Balti	more Ave.	
m	Dep Imp		hero #	6		Gasch's Fu	neral_	Home,	P.A.	Hyatt	svill	e, MD 20781	
20		8	23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that caused the death	. Do not	enter the mode of dyir	ng, such as	cardiac or res	piratory ari	rest,		Approximate Interval Between Onset and Death	
	Physician	4.1	Immediate Cause (Final disease or condition	Congestive							3	Oriset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequ							1		
P	Examine	L	Sequentially list conditions,	b. Coronary ar							-		
11	ted nsit	nine	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Committee of the contract	carrie ou								
L	rtificate be executed ng physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of)	•							_
68760,	e be e			d									_
9	tificat ig phy as th	Medical											
Box		an/Iv	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal		3 □Ectopic pregnanc	y:			23d.	Date of deli-	ivery Day Year	
	The law requires that the death ce tite has been signed by the attendi bage 2 should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of de 9□Unknown	eath	5 ☐ Other (specify) _				i		5	
P.0	nat the	Phy	9 ☐ Unknown Part II. Other significant condition	s contributing to death but not resu	ulting in t	ne underlying cause giv	ven in Part I.		23e. Did to	bacco use o	contribute to	the cause of death?	
	signer d be d	b	Fart II. Other significant condition	5 continuing to accur set not rest	and the	aa,g caacc g			1 🗆 Y	∕es 2 N	lo 3□Pr	obably 4x Unknown	
000	w requir been si should I	eted							24a. Was	an 2	4h Were au	utopsy findings available	
Records,	has b	Completed							autop perfo	rmed?	death?	topsy findings available completion of cause of	
	n: Th ficate or, pag		25. Was case referred to medical				26 Place	of Death (Ch		2 🔀 No	1 □ Yes	2 No	_
₹	Physician: r this certific ral director,	o Be	examiner? 1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outp	atient 3 DOA Ott	hor:	ursing Home			Other (Spec	cify)	
o	ding Physician: The In. After this certificate hat funeral director, page	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tir Inje					now injury of			
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	1113		Yes 2 1	No					
Division or Vital	er der irecto	Certification:	3 Suicide 6 Could no 4 Homicide determin		ome, farn	n, street, factory, office			Location (S City or Tov		u <i>mb</i> er or Ru	ural Route Number,	
	nital or urs afte rral Dir lled in		¥		le d	death agreement 100 c	ilma det	ad plane == '	duo to the	021100/01 0-	d manner co	estated	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ical	29a. Certifier 1 ♣ Certifying (Check only 2 ■ Medical E	Physician: To the best of my kno xaminer: On the basis of examina	wiedge, ation and/	death occurred at the t for investigation, in my	opinion, dea	ath occurred a	at the time,	date and pla	amaimer as ace, and due	to the cause(s)	
	thin 2 the lomblet	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number			29d. Date si	igned (Monti	th, Day, Year)	
	To To Con		1000	· Na		LI C.	12115			04	251	08	
	111		30. Name and address of person w	ho completed cause of death (Iter	n 23a) (T	ype, Print)	000	,			1001	<u> </u>	
	M. I.		DONA LESKUC	4, 9200 Pr	251	CT Lora	0 M	D					
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	1							
	Regist	rar	APR 3 0 20	08 Mayer J.	A	carles							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle Last) Month Dolores May Pachmayr 2008 7:30 A. M April 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Future Care - Chesapeake Anne Arundel Arnold If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 □ M 2 T F 219 12 6940 83 10/18/1924 <u>Marvland</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Anne Arundel Severna Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 306 Benfield Road 21146 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Finan Lula Korb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, Maryland 21146 Sharon O'Neill / Daughter 306 Benfield Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem. 04/28/2008 Crownsville, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part Fni Immediate Cause (Final disease or condition wars resulting in death) Due to (or as a consequence of): Sequentially list conditions

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, ettending physicien for use as the buria detached cate has been signed by page 2 should be detach this certificate has

Physician

/Medical

Examiner Physician/Medical ۾ Be Completed Medical Certification: To To the Funeral Director: After th completely filled in by the funeral

Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show sny injury or other traumatic event, the Marical Examinar research once.

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	uence of):			
resulting in death) Last	Due to (or as a consec	uence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	23c. If yes, outcome of pregn 1	il death 3 □Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions on	entributing to death but not res	ulting in the underlyir	ng cause given in Part I.	23e. Did tobace	co use contribute to the cause of death? 2 No 3 Toporobably 4 Unknown
				24a. Was an autopsy performed	
25. Was case referred to medical examiner?	Un anitali			eath (Check only one)	
	Hospital: 1 □ Inpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	e 6 ☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac fy)	ctory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	ysician: To the best of my kni iner: On the basis of examina and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of cartifier	1		29c. License number	29d.	Date signed (Month, Day, Year)
W 0	1	MD	D5078	25 4	1-23-2008
30. Name and address of person who	completed cause of death (Ite	n 23a) (Type, Print)	, /	111	1/ 11/
Jennifer Ki	edinger 86	OlVeter	anstruyh	1. Uersvil	6 MD 21108

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within 24 hours after To the Funeral Dire

Registrar

DHMH 17 Rev 1/2001

enniter 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 22:28 LINDA PAULETTE REGAN-PAIGE April 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 20%F Yrs Director 57 MARYLAND 219-52-7544 27 1951 FEB. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified any once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Directo BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2406 WELLBRIDGE RD. U.S.A. 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: BLACK þ Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12yrs GOVERNMENT 2yrs SOCIAL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ GARVIE WILLIE ALICE McLAIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamala Regan/Daughter 2406 Wellbridge Rd., Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) Entombment WOODLAWN CEMETERY 05-02-08 WOODLAWN, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1000 Weeked /Medical Due to (or as a consequent of): Examiner Sequentially fist conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 22 consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Ś signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed has feen te 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy perform certific te 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural illed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of dealh (Item 23a) (Type, Print) -335 Quainos MD 31. Date filed (Month, Day, Year) APR 3 0 2008 32. Registrar's Signature State Registrar

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

physician the 35 attending p use signed by the aid be detached for rector, page 2 s or Attending Physician: funeral dir this After within 24 hours after death

To the Funeral Director: Hospital the

Physician

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. In It item 27 is marked other than "natural", or Ite Iny or other traumatic event, the Medical Examine.

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28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. (Check only one) 29b. Signature and title of certified 29c. License number

D62571

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

1500 FOREST GLEN DR : SILVER BROMEL AND

31. Date filed (Month, Day, Year)

APR 3 0 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Kan Kumar 1:05PM 4a. Facility Name (If not institution, give street and number) Apr. 7008 24 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | DeC . | 21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1965 1 X M 2 □ F bec. Guyana Director 454-61-6699 Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at Columbia Maryland Howard 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 USA 8855 Goose Landing Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc ∑Yes 2□No Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Indian þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. **7 Is marked other than "r** Elementary/Secondary (0-12) College (1-4or 5+) U.S. Coast Guard Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bhanmattee Ramkumar Seeram Ravi ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8855 Goose Landing Circle, Columbia, MD 21045 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 Is
any Injury or other trau (spouse) Farah D. Bhatti 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 29 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cemi Crownsville, Maryland 2008 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral S. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ano Viz Immediate Cause (Final **Physician** cephalopathy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a nonsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) the i 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2 □ No 25. Was case referred to medical examiner?
1 □ Yes 2□ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death Fo the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0063653 April 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, Maryland 21044

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State

Registrar

Shawn 31. Date filed (Month, Day, Year) APR 3 0 2008

Evans



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	1.	State Registrar amend #5 I					2. Date of Dea Month	Day	Year	3. Time of Death
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cal ner		. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death			inty of Death	
		2533 W Fayette S			If Under 1 Year	Baltimore If Under 24 Hrs.	D Date of Die	b	timore	
	5.	217-16-3183	. Sex 7. Age 1	88 Yrs.	Months Days		06/05/	y, Year) 1919	MD	iplace (State or Foreig untry)
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Die	10	De. Street and Number	· · · · · · · · · · · · · · · · · · ·		10f. Zip Code 21223			USA		·
era	1	2533 W Fayette S	12. Was Decedent	Ever in U.S. 1	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No	- 14.	Race - Ame Black, White	
by Funeral Director		1 Never Married 2 Married 3 ₩idowed 4 Divorced	Armed Forces? d 1 Yes 2 If Yes, Give Year or Dates:		1 Yes 2 No		nican, etc./	1	ecify: Bla	
		15. Decedent's	Education	16a. De	ecedent's Usual Occu	pation a during most of work	ring		of Business/	
Completed	-	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	5+)	ive kind of work done e. DO NOT use retire				ıl Sec istra	_
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Be	1	7. Father's Name (First, Middle, La Frank Butler	ast)				Unknown			
2		19a. Informant's Name/Relationshi	o (Type Print)	19h M	ailing Address (Stree	at and Number or Rui	ral Route Numb	er, City or To	own, State, 2	Zip Code)
	1	Rosetta Stith/Da			1 Canter				imore	
1	2	0a. Method of Disposition	agneer		isposition (Name of crematory or other pl		Date	20c. Local	tion - City or	Town, State
1		1 Burial 2 Cremation 3			eake Crema		Apr 29 2008	Belts	ville,	Maryland
	1	21. Signature of Funeral Service Li		1443	OO Name and Add		1 Alter	natives		
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		23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cause	d the death. Do not ine.	enter the mode of dy	ring, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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lner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)	•					
Examiner	2	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of)	:					
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edical	2		d							
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		2 DEstanta program	201		23	d. Date of de	
Physiclan/M	2	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant a	2 Fetal death at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			8	Month	Day Year
hys	2	9 Unknown	9□ Unknown							a the equipp of doath
by P		Part II. Other significant condition			he underlying cause	given in Part I.		tobacco use		o the cause of death?
ed	0	Hyperthyroidish	u, hypertis	praemice					0.100	
Completed	<u> </u>						24a. Wa aut	s an opsy formed?	24b. Were a prior to death?	utopsy findings availa completion of cause
mo:	Š						1 ☐ Yes			s 2 No
Be	a)	25. Was case referred to medical examiner?	1	_	12	26. Place of De				
P	- 14	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	tient 2 ER/Outp	atient 3L DUA	4 ☐ Nursing F	dome 5.2 Res			ecity)
C	0	27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month, D		ury V	Vork? □Yes 2□No				
7	icat	2 Accident investig	not be 380 Place of le	niury - At home, farr	n, street, factory, offic		28f. Location	(Street and	Number or F	Rural Route Number,
3	ertit	4 Homicide determine	building,	etc."(Specify)			City of 1	own, State)		
ertifica		29a. Certifier 1 € Certifyin	g Physician: To the bes	of examination and	death occurred at the for investigation, in m	e time, date and plac ny opinion, death occ	e, and due to th urred at the time	e cause(s) a e, date and p	nd manner a place, and di	as stated. ue to the cause(s)
lical Certification:		(Check only 2 Medical	and manner					20d Data	cionad (Ma	nth, Day, Year)
	edical	(Check only 2 Medical one) 29b. Signature and title of certified	and manner s		29c. Lice	ense number		290. Date	signed (IND)	iii, bay, .va.,
	edical	(Check only 2 Medical one)	and manner s	Attendo D Physici	ne 29c. Lice	ense number 00 42383	,		25.0	
	Medical	(Check only one) 2 Medical 29b. Signature and title of certified 30. Name and address of person	and manner s	Attendu D Physici	on Di	00 62383		4	25.0	78

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 7:10 ar, 2008 401G /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution give street and number) Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/2/1950 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 🔀 F 535-86-7326 Cambodia 58 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 □Yes 🍇 🏝 No Anne Arundel Severn MD Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be a 1422 Illinois Ave. 21144 Cambodia Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Cambodian 1 ☐ Yes 2√ No Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile Seamstress 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mon Say Leng Sor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21144 1422 Illinois Ave. Severn, MD Chrep Sor Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 5/3/2008 4 □ Donation 5 □ Other (Specify) Metro Crematory |Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Euneral Service Ligen and Day Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cocclia /Medical Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical for use as ed by the attending getached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 I ive birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1 | Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 R/Outpatient ၉ 1 Inpatient 3 DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

ク

ANG

State

31. Date filed (Mont Registrar

(Check only

29b. Signature and title of certifier

32 Registrar's Signature 11055

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Potster +

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

222587

Columbia maryland 210x4

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 = For State Registrar	State of Marylan	d / Depa		ealth and	l Mental Hy	giene Reg. No.	008	14096	
Physic	cian	1. Decedent's Name (First, Middle, La: Ralph Smith	st)				2. Date of De Month April 2	20, ^{Day} 00	8 Year	3. Time of Death 9:35 AMM	
/Med Exam		4a. Facility Name (If not institution, given Washington Adven			4b. City, Town, or Takoma P		4c. County of Death Prince George's				
Funera Directo		370-20-3073	ex 7. Age (In yrs. In page 1) 7. Age (In yrs. In page 2) 7. Age (In yrs. In page 2) 7. Age (In yrs. In page 3) 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		1925 r ^y e ² 23	9. Birthp Cour Falso	place (State or Foreign ntry) N.C.	
Ne Maryland Ba-f ahow	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	_	, Town or Lo				10a Citizon	of What Cour	10d. Inside City Limits 1 Yes 2 No	
with It		10e. Street and Number 4409 East West Hi	10f. Zip Code 20737				d Stat				
Baltimore, Maryland 21213-UU36 permit. Peges 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "netural", or Items 23a or 28a-1 show any injury or other treumatic event, the Midical Examinar must be nutified at	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	ispanic Origin? n, Mexican, Pu Specify:	14. Race - American Indian, Black, White, etc. Specify: Black					
within 72 houselene.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12) Twelth	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired	during most of v ()		16b. Kind of Business/Industry Residential Cleaning Service				
riand Z Lid be filed Aental Hygi rked other tic avant, I	To Be C	17. Father's Name (First, Middle, Last)									
Mary 12 shou 12 shou 12 shou 12 shou 12 shou 12 shou 12 shou 12 shou 12 shou 13 shou 14 shou 15 shou 16 shou 17 shou 18 shou 1	1	19a. Informant's Name/Relationship (Donald Sharp/Nep)							r, City or Town, State, Zip Code) ngton DC 20020		
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours att Department of Health and Mental hygiene. Important: If Itam 27 Is marked other than "netural", or any injury or other treumatic event, the Midical Exemi		20a. Method of Disposition 1X Burial 2 Cremation 3 E 4 Donation 5 Other (Special	Removal from State	lace of Dispo emetery, crei	osition (Name of matory or other place on Nationa	e) Apr	Date 29,	20c. Locat	ion - City or T		
Balti permit. P Departm Imports eny inju		21. Signature of Funeral Service Lice		2 1	.661 Good	ss of FacilityRe Hope Re	obert G. d SE Wash	Mason ingto	Funera	al Home Inc	
Physicia: /Medica		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PHUMIMA		ter the mode of dyin	g, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Examine		1	Due to (or as a conseq	rsequence of):							
(6 be executed ysicien and le burial-transit	cal Examiner	Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. C/ BUCG Due to (or as a conseq								
I Records, P.O. Box 68. The law requires that the death certificate the has been signed by the attending phy page 2 should be detached for use as the	Physician/MedI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of delivery Month Day Year			
ds, P. puires that the signed by the detaction of the de	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						id tobacco use contribute to the cause of death? □ Yes 2 □ No 3 □ Probably 4X□Unknown			
Record The law requir te has been si age 2 should is	Completed							tas an itopsy findings available prior to completion of cause of death? 1 Yes 2 No			
Of Vital Rec Physician: The lav this certificate has al director, page 2	Be	25. Was case referred to medical examiner?		ath (Check only one)							
Division of Vital Records, for Attanding Physician: The law requires: after death. Director: After this certificate has been sign. Lin by the tuneral director, page 2 should be	tlon: To	1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending 2 Accident Investigation	28a. Date of Injury 28b. Time of 28c. Injury at Work?					me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
Divisi	Certification:	3 Suicide 6 Could not to determined		ome, farm, st					(Street and Number or Rural Route Number, own, State)		
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical									to the cause(s)	
To the Vithin 2 To the Complet	Σ	29b. Signature and title of ourtifur	MO		29c. Licens				signed (Month		
7)	30. Name and address of person who Irving Westney M	.D. 7600 Carr	oll Av		koma Pai	rk, Maryl	and 20	912		
Regi	State strar	31. Date filed (Month, Day, Year) APR 3 0 200	8 Asia Registrar's Sign	ature for	de						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Physician Month Year 25, 6:55 A M Steber April John Stephen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 20, 1966 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🛛 M 2 🗆 F 41 Maryland 217-96-1075 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 20-4 any injury or other traumatic event, the process. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1XXYes 2 ☐ No MD N/A Baltimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21214 USA 3027 Westfield Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 🔀 Married White 1 ☐ Yes 2 X No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Uni Lever Bros. Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julius J. Steber Janet D. Sargent 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3027 Westfield Ave. Baltimore, MD 21214 Mrs. Tammy Steber / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/29/2008 Baltimore, MD Parkwood Cemeterv 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Chansee Kimberly Davidson 5305 Harford Rd Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1, Er ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCELATIC CANCER, **Physician** MAdin 2007 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE-1 ∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a, Certifier Library Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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State

6565 N SHARUS ST, SUITE 209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DANIEUE DIBERMAN, MO

31. Date filed (Month Play, 3°4) 2008

D64395

APRIL 25, 2008

BALTIMINE, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year APRI Day 28 **Physician** 02:03 PM SCHMIDT 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE HOSPITAL N/A Birthplace (State or Foreign Country) If Under 24 Hrs Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) al Security Number 6. Sex **Funeral** Days Hours Min. Months 1 ☐ M 2 🙀 F 216-34-8965 June 10, 1937 Marvland Director 70 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No GLEN Burnie Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 190 Virginia Lane Apt. D 21061 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Acme Pad Co. permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 is marked other that any injury or other traumatic event, the lonce. Sewing Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Butler Robert Ellingson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 190 Virginia Ave., Apt. D, Glen Burnie, Md. 21061 Theodore C. Schmidt (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/2/08 Cedar Hill Cemetery Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) ^{22 Name and Address of Facility} McCully-Polyniak Funeral Home, P 3204 Mountain Rd., Pasadena, Md. Kevin E Ecker 21. Signature of Fundral Service Licensee 21122 Approximate
Interval Between
Onset and Death
SIX ITOURS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTIC **Physician** /Medical Due to (or as a consequence of): FOUR DAYS Examiner EUMON Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBS TRUCTIVE PULMONAR 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? After t Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 28, 2008 ES 000 X-Tiognane MD

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State 31. Date i

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

XIAOGUANG SUN, 3001 SOUTH HANOVER STREET, BALTIMORE, MARY LAND 21225

32. Registrar's Signature

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at
Division or Vital Records, P.O. Box 68760,	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit

Physi /Med Exam

Funera Directo

	1 - For State Registrar		State of Ma	-	-	nent of F icate of		Mental Hy	/gien Reg. N	2111	8	14099
	1. Decedent's Name ((First, Middle, Las	t)					2. Date of D Month		ay Y	ear	3. Time of Death
cian dical	ANN) STO	TT					APEL			208	1000pm
iner	4a. Facility Name (If n	ot institution, give	street and number)		4b	. City, Town, o	r Location of Deat	h	4	c. County of	Death	
	UNIVER	SITY	of MAR	YLAND W	LED C	TR.	BALT	IMORE	-	N/	A	
ıl	5. Social Security Nur	mber 6. Se	7. Ag	e (In yrs. last bir	thday) If	Under 1 Year onths Days		8. Date of B	irth	r) 9	. Birthpla	ace (State or Foreign
r	086-30-635	50	□M 2 ⊠ F	72	Yrs.	Days	Tiodis Ivaii.	April		36 I	lor:	
	Usual Residence of D	ecedent		10 0' T								
_		10b. County		10c. City, Town							10	d. Inside City Limits
5	Maryland	N/A		Da	altim	ore						1 Yes 2 No
Funeral Director	10e. Street and Numb				1	0f. Zip Code				itizen of Wha		ry?
je J	$1252\frac{1}{2}$ Riv	erside A	venue			2	1230			U.S.A.	•	
ne	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was	Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N	0-	14. Race -	America White, e	
	1 Mever Married	d 2□ Married	1 ☐ Yes 2 🔭 I If Yes, Give	No		Yes 2 No	Specify:	to i modify oto.)			Whi	
ò	3 □ Widowed 4 □ Divorced I □ Yes 2 ■ No Specify: S											
iệ	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working											
ਵੁ	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)											
등	3 Widowed 4 Divorced 1 Yes, Give Year or Dates: 1 Yes 2 No. Specify: S											
Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)											
	Whitney Stott Margaret Tingue											
ľ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	Margaret S	S. Smith	(sister)	26	553 D	ay Lily	Run, Th	e Villa	ges,	Flori	Lda	32162
	20a. Method of Dispos			20b. Place of	Dispositio	n (Name of ry or other pla	ce)	Date	20c.	Location - Cit	y or Tov	wn, State
		Cremation 3 □ Other (Specify	Removal from State	Bayvie	ew Çr	ematory	04-2	9-08	Ba1	ltimore	∍, M	aryland
ě	21. Signature of Fund	erer Service Licens	see//	1	2. Na	me and Addre	ss of Facility Lyniak F	·	Uoma	D A		
5	- Char	200	1 XXXII	MAL	130	E. For	t Avenue	unerai . Balti	more	e. Mary	vlan	d 21230
	23a. P. 11. Enter the shock, or heart	disease, or comp	lications that caused	the death. Do r						,		Approximate Interval Between
	shock, or heart		one cause on each li	ne.	1							Onset and Death
sease or condition resulting in death) a. SWA CANCEV Due to (or as a consequence of):										month		
r			Due to (or as	a consequence of	or):							
<u></u>	Sequentially list cond	litions,	b. Due to for as	a Fonsa Nanca	offe						_	
٦Ě	cause. Enter Underly Cause (Disease or in that initiated events	ving jury										
Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):											
edical			d								-	
	IF FEMALE:		23c. If yes, outcome	of pregnancy						Ood Date	f -1 - 1'	
ian	23b. Was decedent p in the past 12 m	regilant	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal death		opic pregnanc	у			23d. Date of Month		Day Year
/sic	1 ☐ Yes 21 🖼 9 ☐ Unknown	No	9□Unknown	time of death	5∐ () (i	ner (specify) _						
Ph	Part II. Other signific	ant conditions of	ontributing to death b	ut not resulting in	the under	lvina cause ais	ren in Part I	23e Did	tobacce	use contribu	ite to th	e cause of death?
þ	h, on		•	at not recalling in	i ino unidor	lynig oddoo giv	on mir arci.					
ted	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1											
l de	.							24a. Wa aut	opsy	24b. We	re autop	sy findings available apletion of cause of
5								per Yes	formed? 2 □ N	dea	ath?	2 ⊠ No
Be (25. Was case referre examiner?	· -					26. Place of De	ath (Check only	one)			
2	1 ☐ Yes 2 ☑ N	0	Hospital: 1 Inpatie	nt 2 ER/Ou	tpatient 3	DOA Oth	ler: 4 ☐ Nursing I	Home 5□Res	sidence	6 □Other	(Specify)
Ë	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	ry 28b. 1	Time of njury	28c. Inju	ry at rk?	28d. Describe	how in	jury occurred		
atio	2 Accident	investigation					Yes 2 □ No					
ific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injuding, et	ury - At home, fa	rm, street,	factory, office		28f. Location City or To	(Street	and Number	or Rural	Route Number,
Certification:			,					J., 5.	,	,		
cal	29a. Certifier 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
Medical	one)		and manner sta	ated.								
Σ	29b. Signature and tit	tle of certifier	- 0			29c. Licens	1		29d. E	Date signed (Month, E	Day, Year)
	Nord	in hour	www	1. Resi	den-	H	17403		A	PRIL	25	12008
	30. Name and address	ss of person who o	completed cause of d	eath (Item 23a) (Type, Prin	t)						
		Chand	nri 22	Sout	H G	REEN	IE STRI	EET, B	AL	TIMOR	E, 1	MD 21201
tate	31. Date filed (Month)		32 degistr	ar's Signature								
strar	Al	PR 3 0 201	UB College	· K	Char	W.						
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Registrar
DHMH 17 Rev 1/2001

		Please	Type or Prin								
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	_	Registrar			Cer	unicale of L		Reg.	No.C 0 0 0	3. Time of Death	
Physicia	an	Decedent's Name (First, Middle, La LORNA MARIA	SCHLOER						Day Year 7 2008	,	
/Medic Examin		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death		
		FRANKLIN Squar	e Hospita	L Cei	nTer	•	dale		Baltim		
Funeral Director			Sex 7. Ag 1 ☐ M 2 F	e (In yrs. las 75	e (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month,				9. Birthplace (State or Foreign Country) Maryland		
		Usual Residence of Decedent									
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	7	10a. State 10b. County	-	10c. City, Town or Location Aberdeen						10d. Inside City Limits 1 ☐ Yes 2 No	
the M	Funeral Director	Maryland Harfor 10e. Street and Number	a	ADE	eraeer	10f. Zip Code		10g.	Citizen of What Co	buntry?	
a or		1413 Creswell R	nad.	21001			1		USA		
ns 23	era	11. Marital Status	12. Was Decedent		13.		spanic Origin? (Speci n, Mexican, Puerto Ri	ify Yes or No-	14. Race - Ame		
r iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀		1	r Yes, specify Cuba 1 ∐ Yes 2 🛣 No	Specify:	ican, etc.)	Black, Whit		
ral", o	þ	3 ★Widowed 4 Divorced			TE Tes ZENO Specify.		7		White		
72 hc 'natu	Completed	15. Decedent's E (Specify only highest g	Education rade completed)		(Give	dent's Usual Occupa kind of work done of	luring most of working		b. Kind of Business	/Industry	
/ithin ne. han '	ld m	Elementary/Secondary (0-12)	College (1-4or	5+)	Homemaker				Own Home		
lled w Hygie her t	ပိ	12. Tather's Name (First, Middle, Las	18. Mother's Name (First, Mic				First, Middle, Mai				
ntal hed ot	Be	Leroy Mallard B				Ellanora	Frederi	n			
hould id Me mark matic	욘	19a. Informant's Name/Relationship			19b. Mailii	ng Address (Street a	and Number or Rural	Route Number, C	City or Town, State,	Zip Code)	
nd 2 sulth ar		Karen Hinckle /	Daughter		1411	Creswell	Road, Abe	erdeen, N	Maryland	21001	
s 1 al f Hea item		20a. Method of Disposition	_	20b. Pla		sition (Name of matory or other plac			c. Location - City or		
Pages ent of nt: If i		1 ☐ Burial 2 ☑Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		' i			orp 5-1-08	TC	owson, Ma	rvland	
mit. I	li		Alseed 4	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2	Name and Addres	un ral Hon			11 4 .	
permi Depar Impor any Ir	13. 4	1/1 male	VIC a	40		1317 Coke	sbury Road	l, Abingo	don, Mary	land 21009	
- 4		23a Part1. Enter the disease, or co shock, or heart failure. List on			Do not en	ter the mode of dyin	g, such as cardiac or	respiratory arrest	t,	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Resource	ory	Faile	ire due	to alve	olar he	emorrhage	Oliset and Death	
/Medical		resulting in death)	Du to (or as	a cons que	ence of):						
Examiner		Sequentially list conditions,	a. Representation as Du to (or as b. Meloc	dyspi	19ST1	c Syn	drome			-	
sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a ronse ue	ence or).						
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<u>a</u> ∟ e											
ficate be physicial sthe bu	Completed by Physician/Medica		d								
leath certific attending p I for use as i	n/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome			75.t.u.!			23d. Date of de		
death atter	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pregnancy □ Other <i>(specify)</i>	/		Month	Day Year	
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e law re has be je 2 sho	plet	Hypothy Poid ism 24a.W							topsy prior to completion of cause of		
The laste has page	l o	, ,				_		performe 1□ Yes 2	ed? death?	es 2 No	
slan: ertific ctor,	Be	25. Was case referred to medical examiner?				Tou	26. Place of Death	(Check only one))		
hysik this o	10	1 Yes 2 No	Hospital:			nt 3 DOA Oth	4 Indising Hon		ce 6 Other (Sp	pecify)	
nding Physician: th. : After this certifics s funeral director, p		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D		28b. Time Injury		Injury at Work? 2 □ No 2 □ No				
tend leath. tor: /	cati	2 Accident investigat 3 Suicide 6 Could not	be 290 Place of in	niury - At hon	me farm s			28f. Location (Stre	(Street and Number or Rural Route Number,		
To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locati City of							Town, State)		
spital ours a neral filled	0	29a. Certifier 1 Certifying	Physician: To the bes	at of my know	vledge, dea	th occurred at the ti	me, date and place, a	and due to the car	use(s) and manner	as stated.	
e Hos 24 h e Fur	Medical	(Check only 2 Medical Ex	caminer: On the basis and manners	of examinati stated.	ion and/or i	nvestigation, in my	opinion, death occurr	ed at the time, da	te and place, and d	ue to the cause(s)	
thin thin omb	- 713		,			29c. Licens		29	d. Date signed (Mo		
	Ž	29b. Signature and title of certifier	·			1 1	10000		11-77-		
F > F 8	Me	29b. Signature and title of certifier	MC			RE	50000		7 6 1-	2008	
L S E 8	Me	1 4084			23а) (Туре					2008	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2:30 P 2008 26, Cecilia Maythorn Sills April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 F 78 May 13, 1929 Virginia <u>220–24–8450</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 No Director Harford Maryland Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 USA. 300 Sunflower Drive Apt. 254 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify. Specify: þ 3 ₩idowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Henry Johnson Virginia Mary Freeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Canvas Place, Bel Air, MD 21015 Patricia Frew / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ ofther (Specify) Mary's Ep. Ch. Cem. 4-29-08 | Abingdon, Maryland 21. Signature of Funera 22. Name and Address of Facility
McComas Funeral Home, P.A. ervice 50 W. Broadway, Bel Air, MD 21014 art1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. art1. Enter the Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence f): Severe eneumonia Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD 2 No 3 Probably 4 Honknown 1 Tyes CHE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 PNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21110 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

SINSCECING M800309070 Division or Vital Records, P.O. Box 68760,

burial-transit attending physician ed by the detached director, page 2 should

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Completed Be

Medical

29a. Certifier

To the Hospital or Attenct within 24 hours after death To the Funeral Director:

4 Homicide

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 V certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier n Cash

29c. License number 063420 29d. Date signed (Month, Day, Year) April, 20, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 upper thesapeake or, Bel Air, Ind 21014 Z. Kharal

State Registrar 31. Date filed (Month, Day, Year) APR 3 0 2008



Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Baltimore

Eastern

4940

32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITE // 31 Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1817pm SEXTON 2008 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs. UNIVERSITY OF MARYLAND MEDICAL CENTER 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2X□ F Days Months Hours Min. Director 55 3-4-1953 Staten Island, NY 217601401 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 □ Yes 2□ No Director Md. Balto. Nottingham 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 72 hours after death with "natural", or items 23a 4304 Necker Avenue 21236 USA by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No White Specify. 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the 12th Grant Manager \$tate Of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred A. Benway Lois Montgomery 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle Maguire DTR. 3036 Milky Way Dover, York Co. PA. 17315 of Disposition (Name of Date 20c. Location - City or Toy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 5-1-2008 Balto.Md. 4 □ Donation 5 □ Other (Specify) Bayview 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home 9705 Belair Rd. Dian Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician LACTIC ACIDU 12 HOURS /Medical Due to (or as a consequence of) Examiner CEMPARTMENT SYNDROME if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and I-transit death certificate be executed PETRO PERI TONEAL

Due to (or as a consequence of): HEMATOMA signed by the attending physician a be detached for use as the burial-Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Tyes 2 TNo o. 9☐Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown s been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page After this certificate 1 Yes 2 No Vital 1∐ Yes 214 No 25. Was case referred to medical rector. To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA or ġ 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Division Hospital or Attending (Month, Day Year) Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 1828 APRIL 25, 2008 MD 10 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) KATIE ZHANG, UNIVERSITY OF MARYLAND MEDICAL CENTER, BALTIMORE, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

ORIGINAL

APR 30 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 26 APRIL **Physician** РМ 3:09 SANDLER HERBERT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE 23 THOMAS CRADDOCK COURT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 08/08/1911 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Yrs. MD 96 212-01-2401 Director Usual Residence of Decedent 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maylori Evan in a rount be notified at 1 □Yes 2 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 23 THOMAS CRADDOCK COURT Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ∐Yes 2 XINo Specify Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HARDWARE OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SANDLER REBECCA SAMUEL LOUIS ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. Pages 1 and 2 s ment of Health ar 23 THOMAS CRADDOCK CT., BALTIMORE, MD 21208 MARY KATHLEEN SANDLER/WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/29/2008 BALTIMORE, MD BETH TFILOH CONG. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Mach be 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myacondial interction **Physician** /Medical Due to (or as a consequence of): **Examiner** 5420-5 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ţō in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy or Attending Physician: The certificate 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🔁 Residence 6 ☐ Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 ☐ Pending investigation 1 ANatural 1 □Yes 2 □ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4/28/08 therdo Ben 40 1)20604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #450, 10755 Fells Rd; Litherville, had 21083 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 20,2008 **Physician** 10:30 atm Albert Toft /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Edgewater South River Health and Rehab If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 0870171933 Months Days Hours 1 ₹ M 2 ☐ F Pasadena, MD 74 219-28-0956 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No iral", or items 23a or 28a-f sh Examiner must be notified MD Director Anne Arundel Harwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20776 4082 Muddy Creek Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1257 es 2 □ No 53-61 If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: <u>Ş</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Goddard Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jasmine Herndon permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic et Grover Toft ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4082 Muddy Creek Rd. Harwood, MD 20776 Stephen Toft Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/23/2008 | Baltimore, MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave App, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final unknown are disease or condition resulting in death) (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 27. Manner of Death Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

28a-f show

"natural", or items

within 72 hours after

2 should be filed within and Mental Hygiene.

Baltimore, Maryland 21215-0036

ng physician and as the burial-transit attending for use as been signed by the should be detached page 2 funeral director, Certification: To After 24 hours after death Funeral Director: filled in by

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

5 Pending investigation 6 ☐ Could not be

determined

Year)

(Month, Day Year)

28c. Injury at Work? 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, APR 3

3 Sulcide

29a. Certifier

Medical

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

MA State 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature

Registrar

within 24 hor To the Fune completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death UL 1. Decedent's Name (First, Middle, Last) Year Month 6:45 P M 23, 2008 Andre Lionel Trepanier Apri] 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Harford Upper Chesapeake Medical Center Air Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Days Hours 1**□**M 2□ F Months Oct. 18, 1928 Canada 380-58-1520 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 300 Sunflower Dr., Apt. 357 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Iron Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorett (nmn) St. John Lionel (nmn) Trepanier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 300 Sunflower Dr. Apt. 357, Bel Air, MD 21014 Martha L. Trepanier / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial Cremation 3 ☐ Removal from State Towson, Maryland Hilltop Service Corp 4-28-08 4 □ Donation 5.□ Other (Specify) 21. Signature of Funeral Service Lidensee McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or vimplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumona Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Life Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Myocardia 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 ☑ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 [Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

Director

Funeral

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Examiner

Physician/Medical

Completed

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Certification:

cal

24 hours after death e Funeral Director:

2 Accident

3 Suicide

4 Homicide

(Month, Day Year) 1 ∏Yes 2 ∏No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Uh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

oper Chesapeake Dr. Bel Air, MD 21014

State Registrar 31. Date filed (Month, Day, Year)

Zubai

6 ☐ Could not be

determined

within 2.

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) April 25 2008

Road Eldersburg MD 21784

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Barbara Supanich, RSM ND D0065485 4-2	d due to the cause(s) Month, Day, Year)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	d due to the cause(s)			
Barbara Supanich 1500 Forest Glen Rd., Silver SPring, MD 20910	d due to the cause(s) Month, Day, Year)			
State Registrar 31. Date filed (Month, Day, Year) 32/Registrar's Signature APR 3 0 2008	d due to the cause(s) Month, Day, Year)			
Registrar DHMH 17 Rev 1/2001	d due to the cause(s) Month, Day, Year)			

DHMH 17 Rev 1/2001

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	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Masaru Ushiro	2. Date of Death Month April 26, 2008 3. Time of Death 6:15 PM
	Examir		4a. Facility Name (If not institution, give street and number) Manor Care — Bethesda	4b. City, Town, or Location of Death Bethesda 4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 571-10-4381 Usual Residence of Decedent 6. Sex 1 M 2 F 91 7. Age (In yrs. last birthda	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nonths Days Hours Min. May 23, 1916 California
	th the Maryland or 28a-f show	Director	10a. State 10b. County 10c. City, Town or Maryland Montgomery Bethesda 10e. Street and Number 10c. City, Town or	1 ☐ Yes 2 🕅 No 10f. Zip Code 10g. Citizen of What Country?
980	hours after death with the Maryland tural", or items 23a or 28a-f show at Exn.ii, or must be redified at	by Funeral Director	5302 Alta Vista Road 11. Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW II	20814 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□Yes 2☒No Specify: United States 14. Race - American Indian, Black, White, etc. Specify: Asian
Maryland 21215-0036	23 23	Be Completed	(Specify only highest grade completed) (Gillerentary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) tographer 16b. Kind of Business/Industry Federal Government
ryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r traumatic event, Ire I	To Be (17. Father's Name (First, Middle, Last) Yokichi Ushiro 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	18. Mother's Name (First, Middle, Maiden Surname) Hana Furuta
Ma	alth an 27 is r			ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alta Vista Road, Bethesda, Maryland 20814
altimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic enones.		The bundle 2 Mg Cremation 3 th Aemoval from State	osition (Name of particle) April 28, Crematorium, Inc. 2008. Location - City or Town, State Bethesda, Maryland
Balt	permit. Departr Importa any Inju	33	21. Signature of Funeral Service Licensee	Name and Address of Facility Obert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 557 Wisconsin Avenue, Bethesda, Maryland 20814
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease for complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Approximate Interval Between Onset and Death
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P.O. Box	requires that the death certifi been signed by the attending hould be detached for use as	Completed by Physician/Me	in the past 12 months?	□ Ectopic pregnancy □ Other (specify) Month Day Year
Records, F	w requires tha been signed should be det	ted by P	Part II. Other significant conditions contributing to death but not resulting in the Parkinson sone	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
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	vit con con	N	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) April 27, 2008
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ORIGINAL.

			For State Registrar	State of Ivi	iaryiano	-	tificate of		ı Mentar Hy	/giene Reg. No.		
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	Exami	ner	4a. Facility Name (If not institu		pita		4b. City, Town, o			4c.	County of Death	1
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	ed b	15. Deced	dent's Education		16a. Deced	ent's Usual Occur	nation				ack
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re,	s 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Pla	ace of Dispos	ition (Name of latory or other place	(a)	Date		cation - City or 1	
im	nit. Pages variment of Portant: If Ite Injury or of Injury or of Injury or of E.		1 2 Burial 2 □ Cremation 4 □ Donation 5 □ Other	on 3 □Removal from State r (<i>Specify)</i>	·		el Cemet	1	Apr 28 2008	Bal	timore,	Maryland
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-09289	tificate g phys as the	edical		d							-	
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Δ.	that the de led by the a detached		Part II. Other significant cond	litions contributing to death t	out not result	tina in the und	derlying cause giv	en in Part I	23e. Did	tohacco us	se contribute to	the cause of death?
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Ä	The law ate has page 2 a	mo										ompletion of cause of
/ita	ician: Th certificate ector, pag	ВеС	25. Was case referred to medi examiner?	cal				26. Place of D	eath (Check only		1 ☐ Yes	Z W NO
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ou c	ding F	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pen	28a. Date of Inju ding (Month, Da	iry y Year) 2	28b. Time of Injury	28c. Injur Worl	k?	28d. Describe	how injury	occurred	
/isi	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Cou	stigation Id not be 28e. Place of inj	ury - At hom	ne, farm, stree		Yes 2 □ No	28f. Location	Street and	l Number or Rui	ral Route Number.
Ö	s after al Dire	Serti	4 ☐ Homicide dete	building, et	c. (Specify)		, ,,			wn, State)		arrisoto (tarrisot)
	e Hospital 24 hours a e Funeral l letely filled		29a. Certifier 1 Certification (Check only 2 Medic	ying Physician: To the best cal Examiner: On the basis o	of my know	ledge, death	occurred at the tir	me, date and pla	ice, and due to the	cause(s)	and manner as	stated.
	To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Medical	one) 29b. Signature and title of certi	and manner st	ated.		29c. License					
	¥ ¥ ¥ 8		200. Oignature and thie of certi	Ka				S - Or	00		signed (Month	
7	n	}	30. Name and address of person	on who completed cause of d		23a) (Tvne P				~~	the state of the s	- 0
_			Good Samariti	an Hospital	, 56=	ما اد	ch Rave	~ Blvd	, Balti	more	- MD	21239
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1, perMD, 68/9 5/12/08 TI 1- For Amend #1, permu (879, 5/9/08 TT Amend #1, permu (879, 5/9/08 TT Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Venkatram Kameswaran 3. Time of Death 11:27 P M 2. Date of Death 27, 2008 **Physician** Kameswaran Venkatram Kameswaran Venkatra April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery 8. Date of Birth (Month, Day, Year)
Sept. 26, 1946 India 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 399-56-2374 61 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Maryla tht and Montal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it., focical Euris. 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6309 Valley Road 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1978 Specify. Specify: Asian Indian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Venkatram Kameswaran Nagalakshmi Sankaran ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 6309 Valley Rd., Bethesda, MD 20817 Raji Padmanabhan/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 30. 20c. Location - City or Town, State 1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2008 Bethesda, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Euneral Service Licensee M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final rostate **Physician** metastatic Cancer - uears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Exami Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 1 ☐Yes 2 ☑No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2. No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 5 Pending investigation 1 Matural Injury ENKHTRAM 1 ☐Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tig Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the within 2 29c. License number
D 43083 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8500 MD DH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDUL CENTER IX \$ 300 ROCKWILLE, MD 2050 32. Registrar's 9ignature State Registrar

KANTESKIARAN 4 AT 108 HELTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:00 M Wischer Noveen 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner medical center LOF Mayland In versity If Under 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Months Days Hours Director 09/15/1950 MD 217-54-2758 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marked as 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 1 Yes 2 No Director Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Completed by Funeral USA 14. Race - American Indian, 311 South Robinson 21224 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) TCI Elementary/Secondary (0-12) College (1-4or 5+) Graphic Designer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Joseph Wischer <u>Anna</u> _Demski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lisa Owens/companion South Robinson St. Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Зφ Apr 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 3 2008 21. Signature of Funeral Service Licensee M01443 Sue Rutter Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 **Physician** bleed Gastro intestina /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Politico South \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 3 0 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23aPt 1,25 per me, 2878,04,29,08dbb Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MONTH RCHDay 4, EXTER Physician 8:55A James A. Wentzel /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 12/4/1951 Hours Min. 1**X** M 2□ F Missouri 56 489-52-3530 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland 7 ha and Mental Hyglene. 7 hs marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Director Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29 Oakway Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: White Completed by 3 ☐ Widowed 4XX Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) +4 Elementary/Secondary (0-12) Steel Fabrication Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should be f nent of Health and Mental I snt: If item 27 is marked o Herman K. Wentzel Ruth Schwanz ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Erin Wentzel/ Daughter 29 Oakway Road Timonium, Maryland 21093 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. = 5 Hilltop Serv. Corp. 3/17/2008 Towson, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Towson, Maryland 21204 Welker Ruck Towson Funeral Home, Inc. 1050 York Road Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Asphyxia LUNG CANCER Physician /Medical Due to (or as a consequence of):
ACUTE BRONCHIAL HEMORRAGE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last EXAMINER Due to (or as a consequence of): Examiner Lung Cancer the death certificate be executed RESPIRATORY ASPHYXIA CERTIFICATION APP attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 ☐ Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown peen: Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an has e 2 page this certificate 1∐ Yes or Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Division Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death to the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 🔀 Certifying Physician: To the by t of my know oge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the box is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and man, er stated. 29c. License number 29d. Date signed (Month, Day, Year) 29h nd title of cel ∕Signat**ų**r D29931 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print)

Registrar

State

CHRISTOPHER

APR 3 0 2008

31. Date filed (Month, Day, Year)

LORENTZ

M.D.

22. Registrar's Signature

7601

OSLER DRIVE, TOWSON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 tate of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 2008 21:00 J. Wilson John /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**⊠** M 2□ F Yrs New York 79 May 11, 1928 Director 108-20-7906 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Montgomery North Bethesda Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 5700 Brewer House Circle Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 MYes 2 No If Yes, Give Korean Year or Dates: Conflict 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>Vice President of Sales</u> Food Service Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, tonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ment of Health and Menta Anna Daly S. Wilson, Sr. ပ Harry and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5700 Brewer House Circle, N. Bethesda, Maryland 20852 Jayne M. Wilson / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Gabriel's Parish
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 Other (Specify) April 11,2008 Potomac, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850 21. Signature of Fune/al Service Licensee Dow Kritu M01193 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical FOR TITUS WED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner Chronic Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and requires that the death certificate be execu Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1⊟ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1∐KYes 200 1 X Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending 1 💢 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death • Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ω April 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Sujoy Tagore, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2 9 2008

#23247

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Month 1735 PM AU APRIL 2008 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES HOSPITAL SAINT SALTIMORE 9. Birthplace (State or Foreign Country) Year | If Under 24 Hrs. Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Date of Birth (Month, Day, Year) **Funeral** Days Months 217-74-8088 Usual Residence of Decedent 1 1 M 2 □ F 7-74-8088 Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the M MARN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 820 ENISE Baltimore. Pate R1 L 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State 1 Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ,2005 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the dilath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE **Physician** KENAL DAYS /Medical Due to (or as a consequence of): Examiner YEAR ACQUIRED IMMUNE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ⊡ No Month 4 Pregnant at time of death 5 ☐ Other (specify) Ö the detached þ ۵. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy certificate death? 1 ☐ Yes 2 No 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 KAJPUT South

Registrar DHMH 17 Rev 1/2001

State

ZESHAN

WARDIAM, NOEL

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Detense

32. Registrar's Signature

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nnie Harkins \		niewski S 1- For State Registrar	tate of Maryl		partment of e <i>rtificate of</i>			Menta	al Hyg		eg. No.	200	8 11	
Physicia al Exami	an/	1. Decedent's Name (First, Midd								Date of Dea Month	Day	Year	3. Time of De 1645 hrs	
ai Exam		Bonnie May Wi 4a. Facility Name (if not instituti	sniewski	umber)	1/	b. City, To	wn orlo	cation of		April 21, 2		: County of Dea		
		13303 Tyla Lane	on, give on oct and t	ionibor,		Baldwi			Dodar			Baltimore Co		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of Bi	rth(MM/	DD/YYYY) 9. B	irthplace (State of	or
Director		247 64 0054	1 M 2 Y F			Months	Days	Hours	Min.		,	Fore	ian	
		217-64-0854 Usual Residence of Decedent	1_M 2XF		53 Yrs.					09/3	0/19	954	ountry) Mary	land
any		10a. State 10b. County		10c. Ci	ty, Town or Locati	on							10d. Inside Ci	ty Limits
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arylar 8a-f	5	10e. Street and Number	CIMOLO		<u>urawrii</u>	10f. Zip C	Code			1	l0g. Citi	zen of What Co	untry?	
the M	ä	13303 Tyla L	ane			21	013					U.S.A.		
with us 23.	Funeral Director	11. Marital Status	12. Was De	ecedent Ever in		Deceden	t of Hispa			oify Yes or No		14. Race - Ame	erican Indian, Bla	ick,
leath ritem	n	1 Never Married 2 N	Married Armed	Forces?	If Y	es, specify	Cuban, N	Mexican, F	Puerto Ri	can, etc.)		White, etc.		
after all, o	by F	3 X Widowed 4 Di	vorced If Yes, Give You		1	Yes 2X	Nio	specify:				Specify: Wh	ite	
nours	pq p	15. Decedent's Education (Sp.			16a. Deceden	s Usual O					16b. I	Kind of Business	s/Industry	
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5-0036 iled within 7 Hygiene. I other than	Completed	12			Servi	ce Di	spat	cher	Name (irst, Middle,		G & E		
filed If Hyg	e C	17. Father's Name (First, Middle					- 1			,	Maideil	(Surname)		
212 212 Menta Mark mark	To B	Thomas Alfred 19a. Informant's Name/Relation			19b. Mailing	Address		Elvi and Numb			mber, C	city or Town, Sta	te, Zip Code)	=======================================
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygene rant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	T	Donald T. Ha	rkins (h	rother)	1							t Virgi		287
e, P and Health	Н	20a. Method of Disposition		201	o. Place of Dispos crematory or oth	ition (Name				Date	20c.	Location - City of	or Town, State	
nor Pages ont of		1 Burial 2 X Crematic			etro Cre		37 T	nc	04/2	4/2008	R Ra	1timore	Marvla	ha
altir nit. I narime norta		4 Donation 5 Other S 21. Signature of Funeral Service		[CT	22. N	ame and A	Address C						l Home,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Media.	1	E. S. X	assalr	/	1117	750 Be	elaiı	r Roa	ь. г d –	Kings	saii vill	le. Mary	land 21	087
Physician		23a. Part I. Enter the disease, of failure. List only one caus	or complications that	caused the dea	th. Do not enter th	ne mode of	dying, st	uch as car	diac or r	espiratory ar	rest, sh	ock, or heart	Approximate Between O	e Interval
Medical ≟xaminer		Immediate Cause (Final diseas	Comp.1 ii	cations	of chronic	alcoh	olism						Dea	th
		or condition resulting in death)	Due to (or as	a consequence	e of):									
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence	e of):									
ted Insit	Exa	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	e of):					·				
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed thours after death. Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	X UNPENDED	AMENDED	27 perME	g879 5/14,	/08 TT								
Box 68760, c death certificate be the attending physic of for use as the bur		IF FEMALE: 23b. Was decedent pregnant in	the Zoc. II yes	s, outcome or pr	egnancy		_	74			23	3d. Date of delive		
Ox 6876 eath certificate attending phy for use as the b	sician/N	past 12 months?	I I LIVE	birth gnant at time of	dooth	tal death her (Speci	3 _	_Ectopic p	pregnand	СУ	- 1	Month	Day `	Year
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Rec The tr	Completed									1 Yes			Yes 2	No
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of Vital Records, ng Physician: The law requir the this certificate has been si meral director, page 2 should b	To	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient					Home 5	1	ence 6 🗸 Ott	ner: Scene	
n of ding Ph. h. After t	on:	27. Manner of Death 1 X Natural 5 Per	(Mor	te of Injury nth, Day,Year)	28b. Time of I	njury 2		at Work?		og. Describe	e now iti	jury occurred		
Sio	icati	2 Accident Inv	estigation 28e Pla	ace of Injury - A	t home, farm, stre	et factory				8f. Location	(Street	and Number or	Rural Route Nun	nber, City
Division pital or Attendin ours after death. reral Director: A	Certification:		uld not be ermined (Specif			, , , , , , , , , , , , , , , , , , , ,				or Town,				
Hosp 24 hox Fune tely fi		29a. Certifier 1 Certifying I	Physician: To the b	est of my knowl	edge, death occur	red at the	time, date	e and plac	e, and d	ue to the cau	ıse(s) a	nd manner as st	ated.	
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the I	Medical	one) 2 Medical Ex	aminer:On the basi and manner	s of examination	n and/or investiga	ion, in my	opinion,	death occi	urred at	the time, date	e and pl	lace, and due to	the cause(s)	
E > E 0	ž	29b. Signature and title of certif	ier	5/1		29c.	License						Month, Day, Year,)
		Capri	Lu	//) .		O.C.N	1.E.			Ap	ril 22, 2008		
		30. Name and address of person				- 64	D - 111		D 040	04				
		Zabiullah Ali, M.D.	Assistant Med	49		n Street	i, Baltin	nore, M	IU 212	U1				
St	tate	31. Date filed (Month 1997) ee	0 2008 32.	Redistrar's Sign	ature	and a	ì							

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State of Maryland / Department of Health and Montal Hygiono

			For State Registrar	tate of Maryland	,	rtificate of L		,	gierie Reg. No.	0000	11:10			
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death			
	/Medic	al	Wallace R. W			4b. City, Town, or	Location of Dogth	April	26	Sounty of Deat	18 3 D			
	Examin	er	4a. Facility Name (If not institution, give stree Doctors Community Ho				nham			ince Ge				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birt	thplace (State or Foreign buntry)			
10	Director		579-34-7046 Usual Residence of Decedent	79				3/7/1	929	Wash	nington, DC			
	arylan show ed at	ŗ	10a. State 10b. County		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	the M 28a-f notifie	rect	MD Prince Geor	ge's Kiv	erdal	e 10f. Zip Code			10a. Citiz	zen of What Co				
	th with 23a or ist be	al Di	5611 59th Avenue				0737		-	ed Sta	-			
19 CC 5-0036	be 'iled within 72 hours after death with the Maryland that Hyglene. ad other than "natural" or items 23a or 28a-f show event, the Medical Exeminer must be notified at	Completed by Funeral Director	1 □ Never Married 2K Married	Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Army		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify:				
- 12 C	רא 72 ה "natu edical	letec	15. Decedent's Education (Specify only highest grade co.	n mpleted)	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired)	ition <i>Juring most of worki</i>	ing	16b. Kin	nd of Business/	Industry			
2121	d withing giene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		Mechanic	,		Tran	sporta	tion			
Sp		Be	17. Father's Name (First, Middle, Last)	C			18. Mother's Name	' '		Surname)				
Maryland	d 2 should be th and Mental 7 is marked o traumatic eve	우	Wallace R. Windsor, 19a. Informant's Name/Relationship (Type.)		19h Mailir	ng Address (Street a	011ie Da			Town State	Zin Code)			
(/)	カモトサ		Mary L. Windsor, wif	· /		59th Ave			-	20737	LIP 6000)			
$\mathbb{N}_{I} \cap \mathcal{A}_{S}$ Baltimore,	jes 1 and t of Healt if item 2 or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remo	20b. Pla	ace of Dispo metery, crea	sition (Name of matory or other place		Date	20c. Loc	cation - City or	Town, State			
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			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cannot be a complete that the complete shock of the complete shock o	ons that caused the death. ause on each fine.	Do not ent	er the mode of dying	g, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset apd Death			
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	ence of):	one					3 day			
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rds, P	quires that in signed build be deta	ed by Pi	Part II. Other significant conditions contributions Chiromic observations	uting to death but not result	ing in the u	nderlying cause give	in in Part I.	23e. Did to			o the cause of death?			
Division or Vital Records, P.O	sician: The law requir certificate has been si irector, page 2 should	Completed by				J		24a. Was autor perfo 1 Yes		death?	utopsy findings available completion of cause of			
Zi.	rslclar s certif	o Be	25. Was case referred to medical examiner? 1 Yes No Hosp	ital: 1 Inpatient 2 ☐ E	-B/Outnatier	nt 3 DOA Othe	26. Place of Death	,		Other (See	oifu)			
n or	ng Phy fter thi	on: To			28b. Time o			28d. Describe I			Chy			
Divisio	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director and the completely filled in by the funeral director and director and direct	Certification:	2 Accident investigation	8e. Place of injury - At hon building, etc. (Specify)	ne, farm, str)		/es 2□No	28f. Location (S City or Tox	Street and wn, State)	d Number or Ri	ural Route Number,			
_	ne Hospita 24 hours ne Funeral pletely filled	Medical C		an: To the best of my know On the basis of examinational and manner stated.										
	To the within To the To the Comp.	Me	29b. Signature and title of certifier R. Dallie	Pm'D		29c. License	2649	2		e signed (Mont				
_	9		30 Name and address of person who complete the complete of the	1.D X001	23a) (Typę,	Print) belle	112 Rd	. Boc	210	MI	20716			
	Sta Registr		31. Date filed (Month, Day, Year) APR 3 0 2008	\$2. Registrar's Signatu	Span	W								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year M Martha Jane Warner 2008 /Medical April 2100 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Mongomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
May 1, 1921 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 295-12-5905 Director 86 Ohio Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20877 333 Russell Avenue, Apt. 623 United States Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygie 7 **is marked other ti** <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: if Item 27 is marked of any injury or other traumatic ew ပ Victor Holly Augspurger Minnie Hester Douglass 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted D. Warner/Son 1429 Burton Avenue, Lutherville, Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
North Monroe 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State May 3,2008 4 ☐ Donation 5 ☐ Other (Specify) Monroe, Ohio Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home (Rockville Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M01360 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Embolism 1 Day /Medical Due to (or as a consequence of): Examiner Breast Cancer 1 Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed J physician and as the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as 1 attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) o the 9 ☐ Unknown signed by t Id be detach ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy perform page ; certificate 1□ Yes 2**X** No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐▼No 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the f 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital

Registrar

State

5

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

John R. Melnick, M.D.,

APR 3 0 2008

Medical

and manner stated.

36. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

911 Russell Avenue, Gaithersburg, Maryland 20879

29d. Date signed (Month, Day, Year) April 28, 2008

08-03146	
Jacob Williams	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

acob vviiliams		1- For State Ce	artment of Health and Mental H <i>rtificate of Death</i>	tygiene Reg.	2008 141	2
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last)	<	2. Date of Death	3. Time of Death	
		4a. Facility Name (if not institution, give street and number) Harbor Hospital	4b. City, Town, or Location of Deat Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 219-13-3658 1 M 2 F 2	last birthday) If Under 1 Year If Under 24Hr Months Days Hours Min	_ `	MM/DD/YYYY) 9/ Birthplace (State or Foreign Country)	
ow any		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location		10d. Inside City Lim	
Maryland 28a-f show	Director	10e. Street and Number	Saltimore 10f. Zip Code	10g.	. Citizen of What Country?	
death with the Maryland or items 23a or 28a-f she must be notified at once	eral Di	2210 Eagle St. 11. Marital Status 12. Was Decedent Ever in L			14. Race - American Indian, Black,	
	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 13 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerlo	io Rican, etc.)	white, etc. specify: Black	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		6b. Kind of Business/Industry	/
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Corr	17. Father's Name (First, Middle, Last) Tames Willams	18.Mother's Nam	ne (First, Middle, Mai	iden Surname)	
MD 21 d 2 should b th and Mer n 27 is mar numatic eve	P P	19a. Informant's Name/Relationship (Type, Print) (Sister)	12316 Kuskin t	Rural Route Number	er, City or Tinn, State, Zip Code)	7
of H		20a. Method of Disposition 20b. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	Place of Disposition (Name of cemetery, crematory or other place)	Date 2	Pauto Md.	
Baltimo permit. Pag Department Important: injury or ot		21. Si mature of Funeral Service Licensee	22. Name and Address of Facility TO SECH TRUSS VINDOTA	Funera	1 Home P. A. 16	
Physician /Medical xaminer		23a. Part I. Enter the bisease, or complications that seused the death failure. List only one cause on each line. Immediate Cause (Final disease a. Cardiac arrhythi		or respiratory arrest	t, Shock, or heart Approximate Inter Between Onset a Death	
XGIIIII O		or condition resulting in death) Due to (or as a consequence of b				
	Examine	if any, leading to immediate Lause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence		· · · · ·		
'60, ate be executed physician and te burial - transit	Medical Ex	d				
3760, ificate be g physici s the buri	n/Med	IF FEMALE: 23b. Was decedent pregnant in the	gnancy	nancy	23d. Date of delivery Month Day Year	
Box 6876 death certificat the attending phed for use as the	ysician/N	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2		Month Bay real	
ires that the signed by the detache	d by Phys	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.		acco use contribute to the cause of death? 2 No 3 Probably 4 Unknow	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Completed			24a. Was an autopsy perform	prior to completion of cause of death?	of
ician: The certificate rector, page	å.	25. Was case referred to medical examiner?	26.Place of Death (Check ER/Outpatient 3 DOA Other,4 Nursi	k only one)		_
of Vi ing Physi After this uneral di	٦ ا	1 V Yes 2 No Inpatient 2 V 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 DOA Other Nursi 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	esidence 6 Other: w injury occurred	
Sion Attendin death.	catior	Pending Accident Investigation	1 Yes 2 No	29f Looption (Str	eet and Number or Rural Route Number, C	City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined (Specify)		or Town, Sta	te)	Jity
To the Howithin 24 l To the Fun Completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	dge, death occurred at the time, date and place, an and/or investigation, in my opinion, death occurred	at the time, date an	nd place, and due to the cause(s)	
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) April 24, 2008	
		30. Name and address of person who completed cause of death (Iter Zabiullah Ali, M.D. Assistant Medical Examine		1201		
St Regist	G, CO	31. Date filed (Month, Day, Year) 32. Restrar's Signat	wre finale			
		e e e		OCME		

VOID

CERTIFICATE

2008-14121

SEE

CERTIFICATE #

			For State		State	of Mary	yland /		rtment o			and M	lental H		000	0	11.100
	8		Registrar 1. Decedent's Name (First	it, Middle, L	_ast)	-				ים וכ	caiii		2. Date of D	Reg. No	K U U	0	3. Time of Death
	Physic /Medi		DOROTHY ANN Z	MANIFO									April	Da 77	200		2250 M
	Exami		4a. Facility Name (If not in			ımber)			4b. City, Tow	n, or Lo	ocation	of Death	riping	40	County of E		04 0 0
			Memorial		sital				Eas.	+01	7			-	Talbo	+	
	Funeral Director		5. Social Security Numbe 219.26.2651	r 8.	Sex XX 1 M 2 F		n yrs. last t 70	birthday) Yrs.	If Under 1 Ye Months Da		If Under Hours	24 Hrs. Min.	8. Date of B (Month, E JAN 25	irth Day, Year 1938	9.		ace (State or Foreign
	pu ,		Usual Residence of Dece 10a. State 10b.	dent		140	Oc. City, To	un or Loc	ation								
	faryla shor	2			VIE0				allon							10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the A	Director	MD QL 10e. Street and Number	JEEN AN	NE5		CENTER	VILLE	10f. Zip Cod	10				10a Ci	tizen of What	Count	7.7.
	death with the Maryland ms 23a or 28a-f show r.must be notified at	Ö	109 RECOVERY	rno w					21617					log. Ci			ry :
	ter death items 2 iner mus	Funeral	11. Marital Status	Dit.	12 Was Dec	edent Eve	r in U.S.	13. W			anic Ori	gin? (Spe	ecify Yes or N	lo-	14. Race · A		n Indian,
Znanjec, Dorothy	ite ite	þ	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ D		Armed For 1 Tyes If Yes, Given Year or D	ve		 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes XX No Specify: 							Black, V Specify:	/hite, e	
7	72 ho natur lical	ed	15. D	ecedent's l	Education trade completed)		16	a. Decede	ent's Usual Oc ind of work do	ccupatio	on	م ما در مساون	in a	16b. K	and of Busine		
orethy	ithin Te.	Completed	Elementary/Secondary		College (1-4or 5+)		life. D	O NOT use re	tired)	ing mos	t of worki	ng				
270	ed w lygier her th	ပြွ	12					ELECT	ONIC TEC	$\overline{}$		_			WESTING	HOUS	Ε
$A = \frac{1}{2}$	be fill Hall Hed out	Be	17. Father's Name (First,	Middle, Las	st)					18	8. Mothe	er's Name	(First, Middl	e, Maider	n Surname)		
(- 2	y lo y lo ould d Mer narke	은	FRANK HECK	-1-121-1-	(T. D.)					_		SAVA					
2) 6	d2st d2st than 7 is n		19a. Informant's Name/R		,				Address (Stre						or Town, Stat	e, Zip (Code)
, C	1 an 1 an Heal em 2		VENDY ZNANIEC 20a. Method of Disposition		DA	AUGHTE			EIGH RD.		WPORT		s VA. 2.	7	ocation - City	or Toy	ın Stata
Znanjec Itimora Mai	ages ent of ft: If It y or o		1 XX Burial 2 ⊡Crea 4 □Donation 5 □ 0	mation 3		State	cemet	tery, crem	atory or other	place)							ii, State
W =	nit. F artme ortan Injur		21. Sign the or Funeral		ary)	11	HULY CI		EMETERY Name and Ad	ddress o		Y 2 ₅	2008	BAL	TIMORE,	MD	
ä	permi Depar Impo any Ir		K. GREGORY		11-6	MO1148	8		Name and Ad K FUNERA CRAIN I				RNIE. M	2106	51		
			23a. Par 1. Enter the hise shock, or heart fails	———	mplications that o	caused the	death. Do	not ente	r the mode of	dying, s	such as	cardiac c	or respiratory	arrest,			Approximate Interval Between
	Physician	10	Immediat Cause (Final disease or condition	. 2134013	End	C1	/	Clare	nic o	his	- 2 (2)	ا داره	v 0	Lucis	1010		Onset and Death
	/Medical	lical iner	resulting in death)	4	Due to	(or as a co	onsequence	e of):	MIC 0	1001	Vuc	_/	C pa	dis	case	+	Ars
	Examiner		Sequentially list condition		b											3	
	B /X #	ine	ir any, leading to immedia cause. Enter Underlying Cause (Disease or injury	le 2	Due to	(01 as a 66	msequence	e or).									
	be executed ician and transit	Examiner	that initiated events resulting in death) Last		C	(or ac a ac	nsequence	n of):								_	
8760	cate be executed bhysician and the burial-transit				Due to	(O) 43 4 CC	nisequence	5 01).									
687	ficate physics the t	edical			d			-				_					
Box	n certi nding use a	N N	IF FEMALE: 23b. Was decedent pregr	ant	23c. If yes, out										23d. Date of	deliver	4
	. 0 00	Physician/Me	in the past 12 month		4□Pregr	ant at time	Fetal deat e of death		Ectopic pregna Other <i>(specify)</i>						Month		Day Year
О	t the by the ache	hys	9 □ Unknown		9∐Unkn	own											
	signed I	by P	Part II. Other significant	conditions	contributing to de	eath but no	ot resulting	in the und	lerlying cause	given i	in Part I.		23e. Did	tobacco (use contribut	e to the	cause of death?
r	w require been sig should b	ed											1/2(Yes 2	□ No 3□	Proba	bly 4 □Unknown
9	law ras be	Completed											24a. Was	s an	24b. Were	autop	sy findings available pletion of cause of
<u> </u>	sician: The law s certificate has b irector, page 2 sl	ĕ											perf 1∐ Yes	ormed? 2 A No	death	1?	Pretion of cause of
ii.	cfan: ertific	Be (25. Was case referred to examiner?	medical						2€	6. Place	of Death	(Check only				
, c	Physic this c	은	1 ☐ Yes 200 No				2 ER/O		O DOA			rsing Hor	ne 5 🗆 Res	idence	6 □Other (S	pecify)	
2	or Attending Physician: ufter death. Director: After this certifica in by the funeral director, i	ii o	27. Manner of Death 1 Natural 5 □	Pending		of Injury th, Day Ye	ar) 28b.	Time of Injury		njury at Vork?			28d. Describe	how inju	ry occurred		
.0.	ttenc death stor: the	cat	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be	00	of injune	At home f	orm otro			s 2 🗆 l		01 1 1	(0)			
Division or Vital Records	I or Attendi after death. Director: A in by the fu	Certification:	4 Homicide	determined	buildi	ng, etc. (S	Specify)	arrii, siree	et, factory, offic	ce		2	City or To	wn, State	e) e)	Hurai	Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	C	29a. Certifier	ertifying P	hysician: To the	best of m	y knowleda	je, death	occurred at the	e time.	date an	d place. a	and due to the	e cause(s) and manner	as sta	ted.
	n 24 h	edical	(Check only 2 ☐ M one)	ledical Exa	miner: On the b	asis of exa ner stated.	mination a	nd/or inve	stigation, in m	ny opini	ion, dea	th occurr	ed at the time	, date and	d place, and	due to t	he cause(s)
_	To the H within 24 To the F I соттрlете	Me	29b. Signature and title of	certifier					29c. Lice	ense nu	umber	-		29d. Da	te signed (Me	onth, D	ay, Year)
			D.	Lo	MD				0	154	14	58		4	-28	- 2	2008
	10		30. Name and address of Bennett		, and,	219	5.	(Type, Pi	shinst	でっ	Si	, E	aston	, 1	1D	21	601
	Sta Registr		31. Date filed (Month, Day	3 0 20	08 32 R	egistrar's	Signature	sha	مثا								

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			1 For State	State of	Maryland / De	partment of F	Health :	and Me	ntal Hygier	ne	14/23		
			Registrar	1 1		erincale or	Dealii		Reg. I	NO.	3. Time of Death		
	Physici	an	Decedent's Name (First, Middle, in a second control of the se	_					Month [Day Year			
	/Medic			ghedew					/03/200	4c. County of Dea	0830 a M		
* .	Examin	er	4a. Facility Name (If not institution, g	•	ber)	4b. City, Town, o							
			7806 Lockney		A . // /- A		oma .		Date of Righ	Montgo	Mery rthplace (State or Foreign		
P	Funeral		5. Social Security Number 6 220 - 08 - 2305	3. Sex 7 1 ☐ M 2 🔀 F	. Age (In yrs. last birthd 53 Yrs	Months Days	Hours	Min.	Date of Birth (Month, Day, Yea /15/195	ar) C	ountry)		
	Director		Usual Residence of Decedent		33				/13/13	55 Eritrea			
	land w		10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits		
	Mary feh	ō	MD Montgo	omery		Takoma P	ark				Mary es 2 □ No		
	the 288	Je C	10e. Street and Number			10f. Zip Code			10g.	Citizen of What C	Country?		
	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or itams 23a or 28a-f ehow event, I're Medical Evalui at must be rectified at	Funeral Director	7806 Lockney	Ave		209	12		E	Eritrea			
	ns 2:	era	11. Marital Status		lent Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Or	igin? (Specif		14. Race - Am			
10	r itar	Ē	1 ☐ Never Married ※ Married	Armed Ford d 1 ☐ Yes 2 If Yes, Give	es?				can, etc.)	Black, Wh			
8	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:	1 ☐ Yes 2 🛣 No	Specify	:		Specify:B1	ack		
Ŏ	2 ho	Completed	15. Decedent's	Education	16a. D	ecedent's Usual Occup	pation	st of working	16b	. Kind of Busines	s/Industry		
21,5	within 72 ene. than na	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4	in	e. DO NOT use retire	id)						
2	d with	ГO.	9th			Housek	eepii	ng		Domes	tic		
b	be filed v tal Hygie d other i	Be (17. Father's Name (First, Middle, La				18. Moth		First, Middle, Maid				
<u>a</u>	Ment Ment arked	70	Aghedew	Negusse				Gide	y Gones	e			
ar	s 1 and 2 should be f Health and Mental item 27 le marked other traumatic ev	1 3	19a. Informant's Name/Relationship			lailing Address (Street	and Numb	er or Rural F	Route Number, Cit	ty or Town, State,	Zip Code)		
≥	2 # Z # Z		Samuel Ghebrem	eschel(Husband)	7806 Loc	ckne				Md 20912		
re	of He		20a. Method of Disposition	3	20b. Place of D cemetery,	isposition (Name of crematory or other pla	ice)	Date	e 20c	. Location - City o	or Town, State		
Ĕ	Pages 1 and thent of Heal tant: If item?		1 XBurial 2 ☐ Cremation 3 1 Other (Spe		Ft Lin	crematory or other pla COIN Ceme	eter	7 4/0	6/2008	Bladen	sburg MD		
Baltimore, Maryland 21215-0036	E 50 5 6		21. Signature of Funeral Service Li	сөрбөө		22. Name and Addre	ess of Facil	itRoge:	r J Mas	on Fune	eral Svc		
Ä	Depa Impo any is		* Kogley	Maso	2	5801 Clev	velar	id Áve	e River	dale Mo	d 20737		
	*		23a. Part1. Ent whe processes, or construction of the shock, or the art air ire. List or	omplications that ca	used the death. Do not	enter the mode of dy	ng, such as	s cardiac or r	espiratory arrest,		Approximate Interval Between		
	Physician		Immediate Cause (5ma)	117 0110 02230 011 02	Ovarian (Onset and Death		
	/Medical		disease or condition resulting in death)	a. Due to (c	r as a consequence of)						1 12		
	Examiner												
	*** 2	Jer	Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury	Due to lo	r as a consequence of								
	certificate be executed nding physician and use as the burial-transit	Examiner	Cause (Disease or injury that initiated events	c									
o,	exectan and and arrigal-to		resulting in death) Last	Due to (o	r as a consequence of)								
760,	te be ysicii	cai		d									
9	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	Physician/Medi											
Box	h cer endir	N.	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Petal death	3 ☐Ectopic pregnand	·v			23d. Date of d			
	death of atten	icis	in the past 12 months? 1 □ Yes XIXNo		nt at time of death	5 Other (specify)				Month	Day Year		
0	by the destached	hys	9 Unknown	9 Olikilot	WII								
Э, Р	es tha igned I be det	ру Р	Part II. Other significant condition	s contributing to dea	ath but not resulting in the	ne underlying cause gr	ven in Part	1.			to the cause of death?		
ğ	w require been sig should b								1 Tes	2¾∑ No 3 🔲	Probably 4 □Unknown		
Vital Records,	law re as bei	Completed							24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of		
R	The late ha	E							performed 1 ☐ Yes 2√2	l? death'	?		
tal		0	25. Was case referred to medical				26. Plac	e of Death (Check only one)	110			
>	Physician: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 X Xo	Hospital: 1 □ In	patient 2 ER/Outp	atient 3 DOA Ot	her: 4 🗆 N	lursing Home	s 5 OResidence	e 6 □Other (Sp	pecify)		
of		H:	27. Manner of Death	28a. Date of	f Injury 28b. Tim		iry at	28	d. Describe how i	njury occurred			
Division	Attending Is death.	atio	1 X Katural 5 ☐ Pending 2 ☐ Accident investiga		, Day Tour,		Yes 2]No					
Vis	Attandi r death. ector: A by the fu	ij	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flace	of Injury - At home, farm g, etc. (Specify)	, street, factory, office		28	f. Location (Stree City or Town, S	t and Number or	Rural Route Number,		
Ö	D in it	Certification:	T I I I I I I I I I I I I I I I I I I I	Dundin	3, 3.0. (0,000,7)			4					
	Hospital		29a. Certifier 12 Xertifying	Physicien: To the	best of my knowledge, o	leath occurred at the t	ime, date a	nd place, an	d due to the caus	e(s) and manner	as stated.		
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical E.	and mann	sis of examination and/oer stated.			an occurred					
	To the within 2 To the complet	Σ	29b. Signature and vitle of certifier	/ \ /	,	29c. Licen	se number 8137	MD		Date signed (Mo			
)			1 Island	1111			2.37		04	/16/200	18		
1	[7]		30. Name and address of person w	no completed cause	of death (Item 23a) (Ty	rpe. Print)							
1-			Jeffrey DY b		810 Conne	ecticut A	ve K	ensin	igton Mo	a 20895)		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signat	5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PUGO 0230 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA /Howard 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2 ☐ F Philliphines 217-63-2105 54 Dec 1, 1953 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b County ral", or Items 23a or 28a-f show Examiner must be notified at MYes 2 No Director Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 USA 5819 Byrn Mawr Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14, Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore. Maryland 21215-0036 1 ☐ Yes 2X No Specify: Asian Specify 3 Widowed 4 Divorced 'natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Building Supervisor Janitorial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Corazon Amodente Roman Ame 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 5819 Byrn Mawr Road, College Park, MD Florie Ame - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of H Important: If Ite any Injury or ot once, 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4/17/2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Ave. Zonsk Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final INTRA-ABDOMINAL BLEEDING **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEVERE ANEMIA Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner NON SMALL COLL LIVING The law requires that the death curtificate be executed that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical the IF FEMALE esn 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s autopsy perform death? 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation after death, 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide within 24 hours a To the Funeral I 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier D052122 APRIL 08, 2008 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 CEDAR LANE, COLUMBIA, MD 21044 PETA-GAY JACKSON SUDTH, MD 31. Date filed (Month, Day State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2008 Physician ROTHY DRIL /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner BALTIMORE WASHINGTON MEDICAL ANNE SURNIE LENTER 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Date of Birth (Month, Day, Year, 10/4/1928 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 Months Days Hours Min DC 212-26-9016 79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentia Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2x No Director MD Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21108 170 Linda Lane USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 🛠 🗙 No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 National Plastics Textile worker 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Rudolph George Hintze Mary Gates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Gertz Niece 1213 St. Stephens Church Rd. Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/16/2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Fuyleral Service Licenses 12 Ridgely Ave. alis Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseasthock, or heart failure se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, b. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) as a consequence of): /Medical Due to (Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-trans and Due to (or as a consequence of): Box 68760. attending physician the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>≥</u> 1 | Yes 2 | No 3 | Probably 4 | Unknown should I Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has rector, page 2 Yes Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 1 npatient 2 □ FR/Outpatient 3 □ DOA this Certification: To funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No death. To the Hospital or Attence within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gler Burnie MO 4050 AciA 6 AVIRIA 31. Date filed (Month, Day, Year) Registrar's Signature State APR 1 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of	Marylan				lealth a Death	and Me	•	giene Reg. No	2008	14126
			1. Decedent's Name (First, Middle, La.	st)						2	2. Date of De			3. Time of Death
	Physici		Mildred E. Brown	1							Month 4	/11/2		11:30 am
The same of	/Medio		4a. Facility Name (If not institution, give		nber)		4b. City	Town, or	Location of	f Death			. County of Death	
			Adelphi House					Δ	delph:	i			Prince G	eorge te
	Funeral		5. Social Security Number 6. S	ex	7. Age (In yrs.	last birthday)		r 1 Year	If Under 2		B. Date of Bir	th	9. Birtl	place (State or Foreign
	Director		186-07-2302	□ M 2X F	9	2 Yrs.	Months Days Hours Min.			Min.	3. Date of Bir (Month, Da 7 / 2 / 19	ı <i>y, Y</i> ea <i>r)</i> 15	Ralt	intry) imore, MD
	70		Usual Residence of Decedent					1			1 2 1 1 7	1.7	Dare	Imore, Im
	ylan		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Mar B-f s	혅	MD Prince (George's				Hva	ttsvi.	11e				1⊠Yes 2□No
	n the	ire	10e. Street and Number				10f. Zi	p Code				10g. Cit	tizen of What Co	untry?
	3a c	<u> </u>	4305 Queensbury	Rd.					2078	1			U.S.A.	
	ms 2	Funeral Director	11. Marital Status	12. Was Dece		.S. 13.	Was Dece	dent of H			ity Yes or No ican, etc.))-	14. Race - Ame	rican Indian,
9	r ite		1 ☐ Never Married 2 ☐ Married	Armed For 1 ☐ Yes	2 🔀 No					, Puerto Ri	ican, etc.)		Black, White	, etc.
03	urs a	by	3 ☐ Widowed 4 🔀 Divorced	If Yes, Giv Year or Da			1 □Yes	2 X No	Specify:				Specify:	hite
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21	hin 7 an "r	혈	(Specify only highest gra	College (1	-4or 5+)	life.	DO NOT L	ise retired	during most)	or working	,			
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pc	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show saumatic event, the Medical Evandret roust be notified at	Be (17. Father's Name (First, Middle, Last)	·					18. Mother	r's Name (First, Middle,	, Maiden	Surname)	
<u>a</u>	ald be Aenti rked	70 E	Edward Thornto	n					Eli:	zabet	h Schu	ıler		
Maryland	shou and N s ma uma	-	19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Addres	s (Street a					or Town, State, Z	ip Code)
	1 and 2 Health a tem 27 is		Robert E. Frank,	Son		4305	Ouee	nsbu	rv Rd.	. Hv	attsvi	11e	, MD 207	81
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any highty or other traumatic event, the Madcal Event fruct must be notified at once.		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of		Da			ocation - City or 1	
2	Pages nent of int: If It		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		state	cemetery, crei	-			, , , ,	, ,,,,,,,			***
量	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service Licer		Met	tropol			acory ss of Facility		4/200 &		exandria	
Ba	permit. Departr Importa any Inju		21. Olgogitate of Fullerial Service/Circle	P. 1	2, -	++					D 4			more Avenue
			23a. Part 1. Enter the disease, or com		1016								attsvill	e, MD 20781
			shock, or heart failure. List only	one cause on ea	ach line.	n. Do not en	er the mo	de oi dyiri	y, such as o	cardiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death
The Park	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cere	bral In	nfarct	ion							18 Hours
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
	Lxummer	L	Sequentially list conditions,	b										
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conseq	uence of):								
	and tran	cam	that initiated events resulting in death) Last	c										
90	oe ex	Ē	roodking in deathy East	Due to (or as a conseq	uence of):								
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical		d										
9	eath certific attending p for use as i	Mec	IF FEMALE:											
Вох	th ce	an/	23b. Was decedent pregnant	23c. If yes, out 1 ☐ Live b	come of pregna irth 2 Feta		Ectopic	oregnancy	v				23d. Date of deli	•
E	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 🕱 No		ant at time of		Other (s		,				Month	Day Year
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p	w requires been signatures should t										1 🗆	Yes 2	X No 3 ☐ Pro	obably 4 Unknown
သ္တ	sw respectively	Completed									24a. Was	an	24b. Were au	topsy findings available
Ä	: The law cate has page 2 s	E							_		auto	rmed?	death?	ompletion of cause of
ā	ician: Th certificate ector, pag		25. Was case referred to medical						00 01		1 □ Yes		1 ∐Yes	2 □ No
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S	l or A after Direc	Ϊ	4 Homicide determined	buildir	of Injury - At he ig, etc. <i>(Specit</i>	(y)	eet, lactor	y, office		20	City or To	wn, State	a) a)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifying Ph	veielen. T- #	hoot of -	udodeo de :	h oes	Latt "	m = al = k	d along	and advise to the		-\	
	Hos 24 hc Fun tely	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the ba	asis of examina	ation and/or in	vestigation	า at trie tin n, in my o	ne, date and pinion, deat	u piace, ar th occurred	id due to the d at the time,	date an	o) and manner as d place, and due	stated. to the cause(s)
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	5 × 5 0	-	250. Signature and the of certiller	' A.	/		29	c. License	PHUINDER			290. Da	ite signed (Month	, Day, rear)
	1.		1 John C	- (901)		_		I	022309)		_Apr	il 12,	2008
~ /	14)		30. Name and address of person who											
1			Phillip W. Poth	8712	Maywoo	d Ave.	, Si	lver	Sprin	ng, M	D 2091	0		
	Sta	ite	31. Date filed (Month, Day, Year) APR 1 6 2008	32. R	egistrar's Signa	deset.	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 6:27 LEONARD CHARLES BENNETT 2008 APRIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Lanham-Seabrook Doctors Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Months Hours Min. 1 XM 2 □ F 05/19/1950 Washington DC 57 578-68-4316 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 ☐ No Upper Marlboro Prince George Director MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20774 USA 3237 Chester Grove Rd. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married Specify: Black 21215-0036 "natural", or 1 ☐ Yes 2X No If Yes, Give Year or Dates: ģ 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than ' Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private 12 Phd 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be John L. Bennett Roberta Hammond 2 19b Mailing Address (Street and Number or Rural Route-Number, City or Town, State, Zip Code) 237 Chester Grove Rd. 19a. Informant's Name/Relationship (Type. Print) Bobbie Bennett/wife 20774 Upper Marlboro, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04/07/2008 Brentwood, Md Ft. Lincoln 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Censes 22. Name and Address of Facility REESE PROFESSIONAL FUNERAL SEVICE 3605 14th St. NW Wash., DC 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardio respiratory collaise **Physician** /Medical Due to (or as a consequence of): Examiner staphylo coccus septicemia ersistent Caquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine endocardi requires that the death certificate be executed Possible and burial-trai Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) detached 9☐Unknown 9 ☐ Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 ☐ Yes 3 Probably 4 Unknown IN SUFFICIENCY page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of arten disease 24a. Was an autopsy performed? Yes 2/2/No certificate has death? 1 ☐ Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division or this funeral 28d. Describe how injury occurred 28a. Date of Injury 28h Time of 27. Manner of Death 28c. Injury at Work? After (Month, Day Injury the Hospital or Attending 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No death. I hours after death.

**Inneral Director: A ely filled in by the fu 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide To the To the To the Funeral Direct 4 ☐ Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58976 2008 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 297, P.O. BOX Greenbelt, MD 20770 Calaf. NiMa 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 Physician 2:20P April 10. Donna Jeanne Bernat /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Oxon Hill 7202 Cloverdale Drive If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Yea 3/6/1957 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Marvland 51 Director 220-48-9611 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10h County 1 ☐ Yes 2 No Funeral Director Prince George Oxon Hill Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or idical Examiner must be r USA 7202 Cloverdale Drive 20745 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Saltimore, Maryland 21215-0036 Specify: <u>ک</u> 3 Widowed 4 Divorced Completed th and Mental Hygiene. It is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Interior Design Design/Decorating 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 흔 Harry Bernat Frances Simon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7202 Cloverdale Dr. Oxon Hill, Md. 20745 Harry Bernat/Father Item 27 Important: If Item any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King David Mem. Park 4/15/2008 | Falls Church, VA. 22. Name and Address of Facility ${ t George\ P.}$ Kalas Funeral Home 21. Signature Funeral Service Licenses 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 al 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cirrhosis of Liver disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🌡 No 9 ☐ Unknown 4□Pregnant at time of death 9□Unknown Month Year 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? 1∐ Yes 2∭ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ů this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: neral Director: within 24 hours a

To the Funeral Completely filled

6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

H 66665

2008

State Registrar

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Medical

00.5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9200 LESKUSKI 32. Registrar's Signature

31. Date filed (Month, Day, Year) APR 1 1 2008

			1 - For State Registrar	State of Maryland		artmer					Reg. No.	2008	Water and the state of the stat	129
	Physicia /Medic		Dorothy Marine							2. Date of De Month April	ath Day 16, 20	Year	3. Time o	A M
XC.	Examin Funeral		4a. Facility Name (If not institution, give 13415 Overbrook I 5. Social Security Number 6. Security Number	ane x 7. Age (In yrs. Ia	ast birthday)	BOY if Unde	vie r1Year	If Under 2	24 Hrs.	8. Date of Bir	Prin	unty of Death ICE GEO 9. Birthy	place (State	or Foreign
lines	Director		578-36-5307 Usual Residence of Decedent	□M 2 ⊠ F 78	Yrs.	Months	Days	Hours	Min.	(Month, Da			nsylva	
	he Marylan 28a-f show otified at	Director	10a. State 10b. County MD Prince Ge		Town or Lo		n Code				10a Citizan	of What Cou		City Limits S 2X No
	ath with t 23a or 2 ust be n	ral Dir	13415 Overbrook I			20	715				USA			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Department of Health and Mental Hylgiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy forjury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 ☐ Yes		spanic Orig n, Mexicar Specify:	gin? (Spe 1, Puerto F	cify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Bla	etc.	
Maryland 21215-0036	within 72 ho iene. • than "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Dece (Give life. House	kind of w DO NOT i	ork done o ise retired	ation <i>luring mosi</i>)	t of workir	ng		of Business/In Ite Ind	-	
and 2	t be filed intal Hyg ed other event, 1	Be	17. Father's Name (First, Middle, Last) George Welton Jon	nes						(First, Middle Henrie	, Maiden Sui	rname)		
Mary	12 should be f h and Mental I 7 is marked of traumatic eve	Ţ	19a. Informant's Name/Relationship (T) Carolyn D. Brow	ype. Print)		-	•		er or Rura	I Route Numb		own, State, Zij	o Code)	
	Pages 1 and 2 nent of Health int: If item 27 i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Pl	ace of Dispo	sition (Na	me of	e)	D	ate		ion - City or T	own, State	
altimore,	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License) Metr	ropoli			s of Facilit		2008 all Fu		ndria, Home	VA	
m T	99 E 8 9	2	23a. Part1. Enter the disease or comp	lications that caused the death				ain F g, such as			e, MD rrest,	20715	Approxima	ite
)	Physician /Medical Examiner		shock, or heart failure. List only o immediate Cause (Final disease or condition resulting in death)	a. Lung Cand Due to (or as a consequ			7						Interval Be Onset and	Death
,092	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequ c. Due to (or as a consequ d.										
.O. Box 68	death certific e attending p d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnal 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3[⊒Ectopic ∣ ⊒ Other (s					23d	l. Date of deliv Month	rery Day	Year
Records, P.	The law requires that the te has been signed by the bage 2 should be detache	by	Part II. Other significant conditions co	ontributing to death but not resu	Iting in the L	inderlying	cause give	en in Part I				contribute to		_
		Completed								24a. Was auto perf 1 Yes		24b. Were aut prior to co death? 1 □ Yes	opsy findings ompletion of 2 No	s available cause of
r Vitt	ding Physician: Th. n. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ★No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie	nt 3 □ C	OA Othe	ar.		(Check only ne 5⊠ Res		☐Other (Spec	ify)	
Division or Vital			27. Manner of Death Y Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of M	28c. Injun Worl 1 □	yat ⟨? Yes 2□		28d. Describe	how injury o	ccurred		
Divis	al or Attention all or Attention after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, st	reet, facto	ry, office		2	28f. Location City or To	Street and N wn, State)	lumber or Rui	al Route Nu	mber,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C		/sician: To the best of my know iner: On the basis of examinat and manner stated.										e(s)
	To the within 2	Me	29b. Signature and title of certifier			29	c. License					signed (Month	, Day, Year)	
sk	(2)		30. Name and addres of person who Harminder S. Seth		, , , , ,		D527		135	Silvor	4/17/		0910	
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 7 2008	32. Registrar's Signar	fort	C GT	JI KU	• , #4	100,	DIIAET	PETII	19,11U Z		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 12:37 PM 10, 2008 Vivian Bridges April 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Under 1 Year | If Under 24 Montgomery Althea Woodland Nursing Home If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Days Hours 1□ M 2**x**F 579-44-3193 86 July 3, 1921 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No DC N/A Washington 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 5403 9th St., N.W. #104 20011 U.S. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 X No f Yes, Give 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Computer Operation Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Johnson Luther Dinkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7423 Atherton Lane West Hill, CA 91304 Arthur Bridges / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/2008 4 Donation 5 Other (Specify) Suitland, MD Lincoln Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. no 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on day ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final erotic Carchovascular Discuse 4 caus

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 Is
any Injury or other trau

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

sician and burial-trans physician as the burial attending p ed by the a detached f signed b peen page 2 s director, After th funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760

		Due to (or as a consequence of):	·
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of).	
ical Exa	resulting in death) Last	Due to (or as a consequence of):	
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23d. Date of delivery Month Day Year	
ed by Ph	Part II. Other significant conditions of	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown	
Complete	Diabetes M	rellitus	24a. Was an autopsy performed 2 prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
Be (25. Was case referred to medical examiner?		(Check only one)
2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hol	me 5 Residence 6 Other (Specify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
9			

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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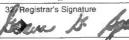
State Registrar 31. Date filed (Month, Day, Year) APR

29b. Signature and title of certifier

29a. Certifier

(Check only one)

16



(Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 **Physician** Iwan Bilous 2008 16 11:29 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 1/3/1925 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Director 220-28-4864 83 Ukraine Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene.
27 is marked other then "neturel", or iteme 23s or 28s-1 show treumstic event, the Medical Examinar count be notified as 1 ☐ Yes 2X No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11005 Sinepuxent Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jakiw Bilous Olena Mehalenko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Parsons/ daughter 5818 Morris Rd., Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other s 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ukranian Nat'l Cem. 4/21/2008 | Boundbrook, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Inneral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a art1. Enter the diseas complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as tonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of ed by the ettending physicien and detached for use as the burial-transit Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No Vital 1 ☐ Yes 2 No To the Hospital or Attending Physicien: within 24 hours effer death.
To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) spital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Division of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No al or Attend s efter death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Mgnth, Day, Year) 30. Name and address of pers mpl death (Item 23a) (Type, Print) 31. Dale filed (Month, Day, Year) State Registrar APR 17 2008 DHMH 17 Rev 1/2001

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** APRIL 11, 2008 7:25 A **BETTY JEAN BURGESS** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**K** F 76 DEC. 14, 1931 WASHINGTON, DC 577-40-8820 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show ner must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 940 BAY FOREST COURT 21403 UNITED STATES Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indi Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married "natural", or Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 真 HOMEMAKER OWN HOME 10 ment of Health and Mental Hy, nt: If item 27 is marked other y or other traumer. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LLOYD SANFORD IDA COOK 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6400 HEATHCLIFF LANE, TRACY'S LANDING, MD 20779 DEBRA A. MacDONALD/DAUGHTER Baltimore, CHESAPEAKE CREMATION 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State APRIL 13.

E CREMATION APRIL 13.

2008 STEVENSVILLE, MARYLAN

22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM

CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE

ROAD, ANNAPOLIS, MARYLAND 21401 Department of Important: If any injury or 4 Donation 5 Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses Will Elson M00672 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of doing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** N (23) (/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 ponths?

1 Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown Month Day Vear 5 ☐ Other (specify) ed by the a Ö 9 ☐ Unknown Δ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, ð 2☐ № 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed certificate 2 40 1 ☐ Yes 2 ☐ No or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 this funeral 28a. Date of Injury 28b Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Division (Month, Day or Attending 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours at Hospital 29a. Certifier LC certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

Registrar

29b. Signature and title

30. Name and address of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

npleted cause of death (Item 23a) (Type, Print

gistrar's Signature

2008 5

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 22, Day 2008 Year 12:32pm м **Physician** Dorothy Virginia Boyer /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Frederick 6008 Jefferson Pike 8. Date of Birth (Month, Day, Dec 10, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Mary Land 1 ☐ M 2 🔀 F 220-01-4056 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 0a. State 10b. County Maryland Frederick Frederick 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21703 6008 Jefferson Pike U.S.A. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify. Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Bd of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lowe Virginia 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6011 Pleasant Drive, Frederick, Maryland 21703 Mr. Dale Boyer, Son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem Gardens Apr 26, 2008 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatu of Funeral Service Oppsee ²²Keeney & Basiord P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 M00706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healf failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebro Vascular Immediate Cause (Final disease or condition resulting in death) Minutes **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Vear Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-23-2008 D43021

State Registrar

Sacch 31. Date filed (Month, Day, Year)

APR 30



ORIGINAL

,0928
P.O. Box 6
Records,
or Vital
Division

	State Registrar 1 Decedent's Name (First, Middle, I	Last)		Certificate of De	Juli	2. Date of D			Time of Death
an	1. Decedent's Name (First, Middle, I	_				Month	Day	Voor	2:15 A
al	Ernest Beaure 4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, or Lo	ocation of Dea		4c. County	y of Death	
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		S. Sex 7. Age X□M 2□F	(In yrs. last bir	rthday) If Under 1 Year 1	f Under 24 Hr Hours Mir	in (Month. D	Day, Year)	9. Birthplace (Country)	olate or Fore
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1.1	Pennsylvania	Chester	Sprin	ng City					YYes 2□I
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
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Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? Mexican, Pu	(Specity Yes or Nerto Rican, etc.)	14. Ra Bla	ce - American Ind ack, White, etc.	_nell;
by Fu	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced		~ ⊬rwλ		Specify:			^{ify:} White	į
ed b	15 Decedent's	s Education	16a	a. Decedent's Usual Occupati	ion	vorkina		Business/Industry	
plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5-	i+)	(Give kind of work done dur life. DO NOT use retired)	any most of v	JOINNY			
Completed	12		Lo	ocksmith	0 11	lama /F	Locks		
Be	17. Father's Name (First, Middle, L.		ر می				dle, Maiden Surna arkev)	
10.	Joseph Arthur		a	b. Mailing Address (Street an		Ila Sha		ı, State. Zin Cod	е)
	19a. Informant's Name/Relationshi		19	b. Mailing Address (Street an 3North Chur	ch S+	reet S	orinaCi	ty, Pen	nsylv
	Joanna Beaure	yaru/Wlie		SNOTTH CHUI of Disposition (Name of ery, crematory or other place)		Date Date	20c. Location	a - City or Town, S	State
	1X Burial 2 □ Cremation			rick Garden	s 4-	28-08			
	4 □ Donation 5 □ Other (Sp 21. Signature of Fugeral Service L			22. Name and Address					
	muchael P	mossello		22. Name and Address	rd Ro	ad, Balt	imore,	Maryla	nd212
	Immediate Cause (Final disease or condition resulting in death)	a. Acute Due to (or as	a consequence		arcti	<u>c</u> n		Ons	A
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03064 State of Maryland / Department of Health and Mental Hygiene Carol Marie Brown Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day April 19, 2008 2005 hrs Carol Marie BROWN Medical Examiner Application Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Hagerstown 427 Mitchell Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Days Min Months Hours Country)Maryland Director 22 220-08-6830 Sept. 28, 1985 1 M 2 X F Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Hagerstown Maryland Washington 28a-f sho other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Director 10g. Citizen of What Country' 10f. Zip Code 10e. Street and Number 21740 USA 457 Mitchell Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No white Specify: f Yes, Give Year Yes 2 X No specify: 3 Widowed 4 X Divorced ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) within 72 hours Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) mit. Pages I and 2 should be filed within 72 partment of Health and Mental Hygiene. portant: If item 27 is marked other than ury or other traumatic event, the Medical ury or other traumatic event, the Medical Baltimore, MD 21215-0036 12 0 none none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marcella Louise Poper Be David Leon Maphis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 128 E. Antietam St., Hagerstown, Maryland 21740 Marcella L. Maphis - mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Fairview Cemetery 4/25/08 Hagerstown, Maryland Donation 5 Other Specify: 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Deensee L. Spien 21740 415 E. Wilson Blvd., Hagerstown, Md. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death /Medical Asphyxia and sharp force injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical signed by the attending physician is be detached for use as the burial -X UNPENDED 44E,27,28a-f, perME,g879, 5/7/08 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. چ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? After this certificate has 2 No ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other: examiner? Hospital: Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 2 Inpatient 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Natural 1 Yes 2X No 5 Pending *s*ubject assaulted April 19, 2008 | Fnd 8:30 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State)
457 Mitchell Ave. Hagerstown, MD determined (Specify) residence 4 Y Homicide

the Hospital or Attending Physician: 'thin 24 hours after death.

the Funeral Director; After this certifin mpletely filled in by the funeral director; within 24 hours at To the Funeral I

29a. Certifier 1

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month Per Xea)

cal

Registra DHMH 17 Rev 1/2001 **DCMF 2006**

State

and manner stated

Assistant Medical Examiner

32. Resistrar's Signature

30. Name and address of person who completed cause of de th (Item 23a)

2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 20, 2008

			1_ State	partment of Health and Nertificate of Death	lental Hyg	giene			
			1. Decedent's Name (First, Middle, Last)	Frillicate of Death	2. Date of Dea	th 3 time of health			
ī	Physici	an			Month 04-11-	Day Year			
	/Medic Examin		OSWALD A. CONTEE 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	04-11-	4c. County of Death			
1	Examin	C)	LAUREL REGIONAL HOSPITAL	LAUREL		PRINCE GEORGE'S			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day	9. Birthplace (State or Foreign Country)			
No.	Director		579-16-9779	Workins Days Flours Will.	04-26-1	922 Wash., DC			
	w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits			
	Maryls f sho ied at	jo.		Bowie		1 8 Yes 2 □ No			
	the 28a-	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?			
	h with		12802 Old Chapel Road	20702		USA			
	deat	Funeral		3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.			
9	or its	Y.	1 € Never Married 2 ☐ Married 1 ☐ Yes 2 € No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	,	Casaitu			
21215-0036	hours tural	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Occupation		Black 16b. Kind of Business/Industry			
5	in 72 n "na"	Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of work e. DO NOT use retired)	king	Tob. Mild of Edsiriess/filddstry			
77	yiene. r thai	E	Elementary/Secondary (0-12) College (1-4or 5+) Cons	truction Worker		Private Industry			
b	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Surname)			
Maryland	ould b Ment arked atic e	P P	Ferdinand Contee		izabeth				
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	s 1 and 2 of Health a ltem 27 is			_	Bowie, M	20c. Location - City or Town, State			
10	ages ent of t: if it y or o		Trabunal 21 ICremation 31 Hemovaliron State 1	Mem. Cemetery 04-1	0-2008	•			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service Licensee	22. Name and Address of Facility	2000	Landover, Maryland			
ä	permi Depar impor any ir		Vack A. Wilson MO1246	Cedar Hill FH 4111	PA Ave.	Suitland, MD 20746			
	a		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory ar	rest, Approximate Interval Between			
Ų,	Physician		Immediate Cause (Final disease or condition Acute Myocardial			Onset and Death 1 day			
•	/Medical Examiner		resulting in death) Due to (or as a consequence of):						
	LXammer	ı.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
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9	rtifica ng ph as th	Nedi	ICECNALS.						
Вох	th ce tendir	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year			
O.	ie dez the at ned fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		World Day Feat			
P.O.	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bbacco use contribute to the cause of death?			
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Re	The la e has	dmc	Depsis		autop perfo	prior to completion of cause of death?			
ta	an: T	Be C	25. Was case referred to medical	26. Place of Dea					
>	Physician; this certificatal director,	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing H	ome 5 ☐ Resid	dence 6 □Other (Specify)			
0	ng Pł		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Tim (Month, Day Year)	e of 28c. Injury at y Work?		now injury occurred			
sio	Attending r death. ector: After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be 38 Place of injury - At home farm street factory office. 281 Location (Street and Number or Rural Route						
Division or Vital Records,	or At after d Direc in by	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Tou	Street and Number or Rural Route Number, vn, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place	, and due to the	cause(s) and manner as stated.			
	ne Ho ne Fui pe Fui	Medical	(Check only one) 2 ■ Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occu	rred at the time,	date and place, and due to the cause(s)			
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)			
			THE THE	D 24721		April 11, 2008			
R			30. Name and address of person who completed cause of death (Item 23a) (Type		1 100 0	0700			
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			SYED SADIQ, MD 1433 Laurel Bowie 31. Date filed (Month, Day, 1/42) 32. Registrer's Signature		e1, MD 2	0708			
	Sta Regist	ate rar	31. Date filed (Month, Day Year) APR 1 6 2008 32. Registrar's Signature						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** A С. CLARK WILLIAM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 75 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Days Hours Min 1 XM 2 □ F NORTH CAROLINA MAY 15 1932 **Director** 239-48-6961 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No PRINCE GEORGE'S T.ANHAM MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20706 5505 DUCHAINE DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: AFRICAN AMERICAN Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT PROPERTY SPECIALIST 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LULA TAYLOR CLARK ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health al
Important: If item 27 is
any Injury or other trau 5505 DUCHAINE DRIVE LANHAM, MARYLAND ERNESTINE CLARK/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State FT. LINCOLN CEMETERY 4/18/2008 BRENTWOOD, MARYLAND J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 nan Ma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last www sumo Due to (o as a consequence of): Examine The law requires that the death certificate be executed valu sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No Division or Vital Acube renal ospital or Attending Physician: hours after death. uneral Director; After this certifice 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 1 ☑ Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Hospital 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 12/08 D0062116

Registrar
DHMH 17 Rev 1/2001

State

MEKLIT

31. Date filed (Month, Day, Year)

APR 1 6 2008

32. Registrar's Signature

7705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WORKNEH

Belle

Point Drive, Greenbelt, MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 02:30M 2008 JANE MILLER CUTLER /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner REGIONAL HICOMICO SA 4364 K KNINSUM If Under 1 Year | If Under 24 Ars. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last b **Funeral** Min. Months Days Hours 1 □ M 2 🖫 F 87 Director 219-05-0586 11/6/1920 Baltimore, MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County a or 28a-f show t be notified at show 1 Yes 2 No MD Director Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 902 Walnut Street 21851 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married r than "natural", or I Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within h and Mental Hygiene. 7 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Sales Hardware 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should b Health and Ment Howard Miller Annie C. Custis or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any Injury or other tr Kim DeMar/ daughter 6816 Seneca Drive, Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crem. 4/17/2008 Salisbury, MD 21804 21. Signature of Funeral Arvice Licensee 22. Name and Address of Facility Holloway Funeral Home, P.A. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the prode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 00 **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year 4□Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 2 No 3 Probably 4 Onknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed certificate 2 No 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 210 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this in by the funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day,

Year)

2008

BA 5

Begistrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 2008 11:50 A M Ina Marie Nunez Chambers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health & Rehabilitation Ctr. Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/14/1918 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Louisiana 89 428-29-1176 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 28a-f 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or is ury or other traumatic event, the Medical Examiner πυξί be in "natural", or items 23a or edical Examiner must be r 2700 South Haven Road 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forceo? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 3 Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Feliz B. Nunez Nastasie Baudoin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Felix C. Chambers/Son 3778 Glebe Meadow Way, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Infortant: If Ite any Injury or ot 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Kalas Crematory 04/14/2008 | Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Findral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Sign 2973 Solomons Island Rd.,Edgewater, Maryland 21037 Part1. Enter the disease, or complications that caused the de. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine death certificate be executed and I-trai Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a d be detached f 9☐ Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page ; performe certificate 2 No 25 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Tyes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 this After thi funeral death.

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: completely filled in by the f

ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describ	e how injury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Spec	ome, farm, street, fact	ory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)		
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and the cause (s) and manner and due to the cause (s) and due to the cause (
ž	29b. Signature and title of certifier		1	29c. License number		29d. Date signed (Month, Day, Year)	
	1 Down	el m		DO 051	897	4-14-2008	
	30. Name and address diperson who	completed cause of death (Ite	m 23a) (Type, Print)	Midello	h lode	Pilm 5	
	9053	Cherro	lee- By	we Stel	100 E	hertaty 21045	
te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature				
ar	APR 152	008 Streve	it appeal			,	

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State of Maryland / Department of Health and Mental Hygiene

17. Father's Name (First, Middle, Last) 18. Mouther's Name (First, Middle, Last) 19. Martha Mary Thomas 19. Informatis Name/Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24.9 Taylor Street, Strasburg, Virginia 22657			1	For State Of Maryland / State Registrar		ificate of Dea			eg. No.	108		40
Examination of Proceedings of Procee			ın					Month	Day		3. Time of 8	A ^M
St. Mary s. Surface Center Control Contro	,		_			4b. City, Town, or Loca	ation of Death					
Social Security Number Company The Com		LXdiiiii		St. Mary's Nursing Center		Leonardto	wn		St.			
Top State Top	**			5. Social Security Number 6. Sex 7. Age (In yrs. last b			ours Min.	(Month, Day	, Year)	1		Foreign
Thomas Leonard Combs, Sr. Thomas Leonard Combs, Sp. Thomas Leonard Combs,		yland now at			own or Loc	ation				1		
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Thomas Leonard Combs, Sr. Thomas Leonard Combs, Sp. Thomas Leonard Combs, Sr. Thomas Leonard Combs, Sharon		r 28g	ire	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?	
Thomas Leonard Combs, Sr. Thomas Leonard Combs,	di sajit	h wit		22680 Cedar Lane Court								
Thomas Leonard Combs, Sr. Thomas Leonard Combs, Sp. Thomas Leonard Combs, Sr. Thomas Leonard Combs, Sharon		ms a	ner	11 Marital Status 12. Was Decedent Ever in U.S.	13. W	as Decedent of Hispan Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto I	cify Yes or No- Rican, etc.)	14. Ra Bl			
Thomas Leonard Combs, Sr. Thomas Leonard Combs, Sp. Thomas Leonard Combs, Sr. Thomas Leonard Combs, Sharon	36	urs after al", or Ite		1X Never Married 2 Married 1 ☐ Yes 2X No						eify:		
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Thomas Leonard Combs, Sr. Thomas Leonard Combs,	7	withi ene. than he M	E I		Dis	abled			Disa	bled_		_
Physician Medical Examiner The physician Medical Examiner Th		filed Hygi other ent, t		17. Father's Name (First, Middle, Last)			Mother's Name	(First, Middle,	Maiden Surna	ame)		
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Physician Medical Examiner The physician Medical Examiner Th	<u> </u>	shoul nd M			9b. Mailin	g Address (Street and I	Number or Rura	l Route Numbe	er, City or Tow	n, State, Zij	p Code)	
Physician Medical Examiner The physician Medical Examiner Th	$\mathbf{\tilde{z}}$	nd 2:		Sharon Halpin / Niece 24	49 Ta	vlor Stree	t. Stra	sburg,	Virgin	ia 22	657	
Physician Medical Examiner The physician Medical Examiner Th		tem tem		20a. Method of Disposition 20b. Place	of Dispos	sition (Name of	; c	ate	20c. Location	n - City or T	own, State	
Physician Medical Examiner The physician Medical Examiner Th	ō	ages ent of t: If i		1 M Burial 2 □ Cremation 3 □ Removal from State					Great M	ills. N	Marvland	
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Physician Medical Examiner To graph of the past 12 months of the	$\mathbf{B}^{\mathbf{a}}$	Deperment Deperm		Muchault Darchner							,	
Due to (or as a consequence of): Due to (or as a consequence of):		Physician	0 1	Immediate Cause (Final	To not ente	er the mode of dying, su	uch as cardiac o	or respiratory a	rest,	9	Interval Bet	ween
Sequentially list conditions, if any, leading to immediate gause. Enter Underlying cause. Enter Underlying cause contributed events in the past 12 months? 23c. If yes, outcome pf programmy in the Underlying cause given in Part I. 23c. Date of delivery Month. Day Year.	1			regulting in death)	ce of):							
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Compared to the cause of design Compared to the cause of the cause	ij.		je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence cause. Enter Underlying								
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FFEMALE:	ó	exection and and rial-tr		resulting in death) Last Due to (or as a consequence of):								
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9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Innknown 24a. Was an underlying cause of death 1 Yes 2 No 3 Probably 4 Innknown 24a. Was an underlying cause of death 1 Yes 2 No 3 Probably 4 Innknown 24a. Was an underlying cause of death 1 Yes 2 No 3 Probably 4 Innknown 25b. Was case referred to medical examined of cause of death 1 Yes 2 No 3 Probably 4 Innknown 25c. Was case referred to medical examined of cause of death 1 Yes 2 No 3 Probably 4 Innknown 25c. Was case referred to medical examined of cause of death 1 Yes 2 No 3 Probably 4 Innknown 25c. Was case referred to medical examined of cause of death 1 Yes 2 No 3 Probably 4 Innknown 25c. Was case referred to medical examined of cause of death 1 Yes 2 No 3 Probably 4 Innknown 25c. Was case referred to medical examined of cause of death 1 Yes 2 No 1 Yes 2 No 3 Probably 4 Innknown 25c. Was case referred to medical examined of cause of death 1 Yes 2 No 1 Yes			ledi			252.00						
The paper of the p		ne death cer the attendin hed for use	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 25c. If yes, outcome professional to the past 12 months? 4 ☐ Pregnant at time of death	eath 3 🗆							Year
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner Death 1	٩	uires that the signed by detaction	by	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause given ir	n Part I.					
25. Was case referred to medical examiner? 1	Recor	The law requered to has been age 2 shou	omplete					auto perfe	psy ormed?	death?		available ause of
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The state of the s		ding Phy T. After thi funeral		1 ■ Natural 5 Pending (Month, Day Year)	Work?	8c. Injury at Work? 28d. Describe how injury occurred						
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and difference of person who completed cause of death (Item 23a) (Type, Print) David Federle, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636 31. Date filed (Month, Day, Year) 29a. Certifier (Check only one) 12 Certifiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Federle, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636	Divisi	after death after death Director: d in by the	ertifical	2 Laccident 3 Suicide 4 Homicide 28e. Place of injury · At home, farm, street, factory, office determined 28f. Location (Street and Number or Rural Route No. City or Town, State)								nber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Federle, M.D. 24035 Three Notch Road, Hollywood, Miryland 20636 31. Date filed (Month, Day, Year) 32 Pegistrar's Signature		Hospita 24 hours Funera stely fille		(Check only 2 Medical Examiner: On the basis of examination	edge, deat n and/or in	h occurred at the time, evestigation, in my opin	date and place ion, death occu	and due to the rred at the time	cause(s) and , date and pla	l manner as ce, and due	stated. to the cause(s)
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31. Date filed (Month, Day, Year) 32 Registrar's Signature	/	200					Marri 1 and	20626				
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DHMH 17 Rev 1/2001

ORIGINAL

08-0260)6
William	Dancy

illiam Dancy		State of Maryland / Department of Health a For State Certificate of Death egistrar	and Mental Hygie	ene Reg. N	200	-
Physicia ledical Examin	n/	I. Decedent's Name (First, Middle,Last) William D. Dancy	M	ate of Death lonth Day oril 2, 2008	y Year	3. Time of Death 1500 hrs
eð (la. Facility Name (if not institution, give street and number) 4b. City, Town,	, or Location of Death		4c. County of Death	
†	4	Prince George's Hospital Cheverly 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		Date of Birth(Mi	M/DD/YYYY) 9. Birt	hplace (State or
Funeral Director	L	215-86-1241 1XM 2 F 38 Yrs. Months E	Days Hours Min. S	ept.7,	1969 Foreig	Baltimore untry)Maryland
v any		Usual Residence of Decedent 10a. State	~~~			10d. Inside City Limits 1 Yes 2 No
Aaryland 28a-f show any 1 at once.	ctor	10e. Street and Number 10f. Zip Cod	de	10g. C	Citizen of What Cour	ntrv?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		1512 Carolina, Court 207	/ 4 f Hispanic Origin? (Specify			ican Indian, Black,
Jeath wit	uneral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of If Yes, specify Cu	uban, Mexican, Puerto Rica	in, etc.)	White, etc.	ack
s after c	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occ		done 16	Specify: D1	
2 hours		Elementary/Secondary (0-12) College (1-4 or 5+)	g life. DO NOT use retired)		onstruc	
036 vithin 7 ene. er than	Completed	12 Inspector	18.Mother's Name (Firs			CIOII
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	Be Co	17. Father's Name (First, Middle, Last) William Dancy	Loretta	Hall	on ourname)	
도 등 등 등 à	2		Street and Number or Rural lina, Cour			
	-	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Crematory or other place)			oc. Location - City of Vashingt	
		ROCKCIEER Cen	dress of Facility Gene		_	
Balt permit Depart Import injury	7	TAGINALIA DIGINA 5732 GA	A., Ave., N	1.W. Wa	ash, D.C	20011
Physician		23a. Part I. Enter the disease, or combinations that caused the death. Do not enter the mode of dy failure. List only one cause on each line.	ying, such as cardiac or res	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
xaminer	1	Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to Head Due to (or as a consequence of):				- Bookin
		Sequentially list conditions, b.				+
	Examiner	cause. Enter Underlying Cause		_		
cecuted n and - transit		events resulting in death) Last Due to (or as a consequence of): d.				
ਰ ਜ਼ੁਰੂ	edical	UNPENDED AMENDED				
3760 ificate l ig phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delive Month	pry Day Year
Box 68760, e death certificate be the attending physicied for use as the buried for the buried for use as the	sician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify,)			
D. BC t the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	iuse given in Part I.			o the cause of death?
ords, P.O. Inwrequires that the as been signed by to should be detached.	d by				2 ✓ No 3 Pr	obably 4 Unknown autopsy findings available
ords aw requ as been 2 should	Completed			24a. Was an autopsy performe	prior to	completion of cause of
tal Rec sian: The la certificate h	Com	26	Place of Death (Check only	1 Yes 2	No 1 🗸	Yes 2 No
/ital rsician rsician	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other:		esidence 6 Oth	er:
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1. Death 28a. Date of Injury 28b. Time of Injury 2b.		d. Describe hov ubject was s	v injury occurred hot	
Vision or Attend after death. Director:	catic	2 Accident Apr 1, 2008 2045 hrs Nestigation 28e. Place of Injury - At home, farm, street, factory, of	ffice building, etc. 28			Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street ((A✓)	53	or Town, Stat 53 Quincy Str	eet , Hyattsville ,	MD
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the tire (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my one of the control of the co	ne, date and place, and du pinion, death occurred at th	ie to the cause(s ne time, date an	s) and manner as st d place, and due to	ated. the cause(s)
To with To com	Mec	and manner stated.	icense number	2	29d. Date signed (A	
5		JMI /	O.C.M.E.		April 4, 2008	
		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street,	, Baltimore, MD 2120	01		
	tate	31. Date-filed (Month, D2008) 32. Registrar's Signature				
Regis	uel				enies	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3:00 P^M April 2008 Thomas Knox Dempsey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's St. Thomas More Nursing Home Hyattsville Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**∑**M 2□F Yrs. Director July 2, 1937 240-54-0663 70 North Carolina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 □ No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be 20003 United States 1229 G Street, SE #404 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: **Black** Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years General Contractor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas McKinney-Dempsey Madaline Freeman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Lee Dempsey - Wife 1229 G Street, SE #404 Washington, DC 20003 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 6 Quantico Nat'l Cemt. Apr 16, 2008 Injury Triangle, VA 21. Signa o of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Par Nonter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock a heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Adeno CARCINOMA LUNG **Physician** disease or condition resulting in death) 4KGRS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trai Due to (or as a consequence of) Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Dysphagia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pleural effusion page 2 s performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Queensburg Rd Hyattsu; 1/4 MD 2020

State Registrar

Medical

31. Date filed (Month, Day, Year APR 1 1 2008

within 24 hours a

			For State	State of Mar				Mental Hygie	ene	
	3-		Registrar 1. Decedent's Name (First, Middle, Las	41	Ce	rtificate of	Death	g. No. 2008 3. Time of Death		
2	Physici	an	Narciso Molina		Diam				Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	April 13	4c. County of Dea	5:45p [™]
	Examili	iei	Heartland Hyattsv			**	sville		Prince G	
¥.	Funeral		Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	9 Bir	thplace (State or Foreign
÷	Director		230-49-4346	5:	3 Yrs.	montrio Days	Tiours Will.		,1955 E1	
	land w		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or Lo	cation				10d. Inside City Limits
	Mary I-f she fied a	to	MD Prince G	eorge's	Mount Rai	nier				1X Yes 2 □ No
	th the	irec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	23a ust b	ral	3305 Otis St.			2071	2	F	El Salvado	or
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 X Yes 2□ No	Specify:		Specify:	
215-0036	2 hou attura cal E	ed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	z ādorān	b. Kind of Business	ite /Industry
215	hin 7. e. an "n Medi	ple	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wor d)	king		
21	ed wil ygien ier th	Completed	6th		Dia	shwasher			GI Friday	s Inc.
and	be fill ad oth even	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	iden Surname)	
Maryland	should be fand Mental by marked of umatic ever	ဥ	Felipe Molina 19a. Informant's Name/Relationship (7)	ino Briet)	10h Maili	an Address (Chroad	Balvin			
Ma	C1 (0 := 60			ist e r)				<i>ral Route Number, C</i> • W ashin gt		
ē,	s 1 and 2 if Health item 27 i	-	20a. Method of Disposition		20b. Place of Dispo cemetery, cre	sition (Name of	and Ave		c. Location - City or	
Ë	Page nent o nt: If	1	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Family Co		4	0-08 Sa	n Miguel.	El Salvador
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		21. Signature of Funeral Service Licen	see	25 7 () 25	2. Name and Addre	ss of Facility W . H	. Bacon F	uneral Ho	ome, Inc.
	82789		Wanda C.	pacon,				Washingt		010.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	blications that caused the one cause on each line.	ne death. Do not en	er the mode of dyir	ng, such as cardiad	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a CARD	10 Pulmor	YARY 1	TRESI			Onset and Death
	Examiner	П		Due to (or as a	consequence of):	TAC.	11150			
		je l	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):	Inc	CIVON			
	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
Ő,	e exe ian ar urial-t	EX	resulting in death) Last	Due to (or as a	consequence of):					
68760,	cate b	dical		d						
0	death certific attending p	/Me	IF FEMALE:	23c. If yes, outcome pf	nregnancy				li .	
Вох	atten for u	cian	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	Day Year
P.O.	at the de by the a tached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
	The law requires that the death certif ite has been signed by the attending tage 2 should be detached for use a	by Pi	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
Records,	w require been sig should b							1 ☐ Yes	2 ⊠ No 3□P	robably 4 Unknown
ecc	e law r has be	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
E R		Som						j performe	d? death? ☑No 1 ☐ Yes	· .
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		To:		th (Check only one)		
ō	dir dir	၉	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatier		4 Nursing H	ome 5 Residence		ecify)
	Attending Pr r death. ector: After th by the funeral	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)		Wor	yai k? Yes 2∐No	28d. Describe how injury occurred		
Division	or Attend after death. Director: / in by the fi	fica	3 Suicide 6 Could not be determined	Zoe. Place of injury	- At home, farm, str			28f. Location (Street	et and Number or Fi	lural Route Number,
Ö	pital or A	Certification:	4Normicide	building, etc.	(Specify)			City or Town,	State)	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I		(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e	my knowledge, deat	h occurred at the til	me, date and place	e, and due to the cau	se(s) and manner a	s stated.
	To the Hos within 24 ho To the Fun completely	Medical	one)	and manner state	ed.					
	Wil Villa	-	29b. Signature and title of certifier	MA		29c. Licens	L() a	29d	Date signed (Mon	in, vay, rear)
				MU		1 114	1) +1	/)	1111	ノ しいと
	1 6)		30 Name and address of person who	completed cause of doc	th (Item 23a) /Tues	Print!	35 1)			
U	12)		30. Name and address of person who of the control o	7 -0	th (Item 23a) (Type,	Print)	WAY (TRECTOR	ei MAR	(LAND 2017)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Physician A $^{\text{M}}$ April 16, 8:55 Josephine DeToro /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Crofton Anne Arundel Crofton Convalescent & Rehab. Ctr. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 ☐ M 2 🔀 F 14, 1919 Pennsylvania 182-16-4043 88 Director Dec. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 No notified Directo Anne Arundel Crofton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 2131 Davidsonville Rd. 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 10 1 ☐ Yes 2 No Specify: White Specify. ģ 3 Nidowed 4 Divorced "natural", Completed r than "natur the M dical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any injury or other traumatic event, the once. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Kovacic William Garm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 388 Gambrills Rd. Unit 244 Gambrills, MD 21054 Dolores Raimond / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restland Mem. Park 4/22/2008 East Hanover, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home ern Bowie, MD 20715 6512 NW Crain Hwy. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ve heart tailure Examiner CONGR57 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine I or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∏ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year, Injury Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours a

State Registrar

Medical

29b. Signature and title of certifier

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause

Crofton, mo 21114 Berez, Paul mo

31. Date filed (Month, Day, Year)

29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year Month **Physician** MARGARET M. DAN 4a. Facility Name (If not institution, give street and number) DANIHER I pm M 04 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Ma T. Marc NURSING LEWTER eon redtion MARY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🗸 F 194-09-O Yrs 6700 Pennsylvannia Director 2-10 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral', or items 23a or 28a-f ehow Exertities must be notified at 1 Yes 2 □ No Director Maryland | St. Mary's Leonardtown 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 22680 Cedar Lane Ct. Apt.2309 20650 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after ind Mental Hygiene. marked other than "natural", or Itei imatic avent, the Medical Exemiter 1 □ Yes 2\X\No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Rug Cleaning 12 t of Health and Montal Hyu 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Patrick Cullinan Anna Cullinan Loughery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Joseph Michael Daniher/ Son P.O. Box 474 Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 № Burial 2 Cremation 3 Removal from State ö permit Page Department Important: If * 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 04/30/2008 Pittsburgh, PA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any ir Brinsfield Funeral Home, 22955 Hollywood Koad Leonardtown, Maryland 20650 Kyle S. Simons M01206 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. ac or respiratory arrest, Approximate I terval Between I nset and Teath Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dust to for a The law requires that the death certificate be executed physician and s the burial-transit Due to (or as P.O. Box 68760 Physician/Medical as attending IF FEMALE use 23d. Date of deliver 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Fctor bregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à pe 3 ☐ Probably 4 **@**Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2€ No ၀ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 1 within 24 hours at To the Funerel D the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) le of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

State Registrar 30. Name and address of person who completed ca James P. Jarboe,

2008

31. Date filed (Month, Day, Year)

24035 Three Notch Road, Hollywood Maryland 20650

se of death (Item 23a) (Type, Print)

. Registrar's Signature

M.D.

32

		State of Maryland / Depa		•	2008 14146
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Bernard Francis Ditmore, Jr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April	Day Year 3: 16 P ^M 4c. County of Death
		Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $205-24-3829$ $1 $	Havre de Grace If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yes	Harford 9. Birthplace (State or Foreign Country) Pennsylvania
A E , BERMARI S P M with the Maryland a or 286-1 show the rediffed at	ctor	· · · · · · · · · · · · · · · · · · ·	de Grace		10d. Inside City Limits 1 ⊠ Yes 2 □ No
70 4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-	Funeral Director	1105 Leslie Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 21078 Vas Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto R		Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc.
1215-0036 within 72 hours after dener than "natural; or Itam		1 Never Married 2 Married 1 Says 2 No If Yes, Give Year or Dates: Korean 1 15. Decedent's Education 16a Decedent 16a Dece	Yes 2 No Specify:	16h	Specify: White Kind of Business/Industry
0	Be Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	ind of work done during most of working O NOT use retired) . NC-NCC		Financial Officer
re, Maryland set in a set and 2 should be filed. If Health and Mental Hygitem 27 is marked other other traumatic event,	ToB		Mary Sma Address (Street and Number or Rural Leslie Rd., Havre	Route Number, Cit	
Page Page ment o		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremit from State Evans Fund		2008 F	Location - City or Town, State Orest Hill, MD
Balt permit Depart Import any inj		Part1. Enter the disease, or colonidations that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	123 S. Washington rthe mode of dying, such as cardiac or	St., Hav	re de Grace, MD 2107 Approximate Interval Between
/Medical Examiner prize signary and prize reason prize re	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	cardie Vasc.	erlar o	iscore
Box 687 sath certificate attending phys	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
cords, P.O. w requires that the debeen signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.		o use contribute to the cause of death? 2 🛣 No 3 □ Probably 4 □Unknown
Vital Rec sician: The law certificate has b	e Completed	25. Was case referred to medical	26. Place of Death (24a. Was an autopsy performed: 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
- > · · · · · · ·	Certification: To B	examiner? 1 X yes 2 No Hospital: 1 Inpatient 2 XER/Outpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation Could examiner? 1 Day a year) 28b. Time of Injury (Month, Day Year)	3 □ DOA Other: 4 □ Nursing Home		6 □Other (Specify) jury occurred
sis		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, an	City or Town, Sta	(s) and manner as stated
To the Ho within 24 To tha Fu completel	Medical	(Check only one) 25 Medical Examiner: On the basis of examination and/or invessed and manner stated. 29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
5+1		30. Name and address of person who completed cause of death (Item 23a) (Type, P BEAWARD YUKWA MIN, DME 1614 CHUR	MININE RUID BE	L AIR W	d 2105
Stat Registra	-	31. Date filed (Month, Day, Year) APR 2 1 2008 32. Tegistrar's Signature			

08-02851 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sean D. Edwards State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Physician/ Month Day April 12, 2008 0434 hrs Medical Examiner D. **EDWARDS** SEAN 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death W/B Rt 214 Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Days Country HIO Director 1 X M 2 147-74-1297 33 21 <u>Feb</u> Usual Residence of Decedent 10d. Inside City Limits any. 10b. County 10c. City, Town or Location 1 X Yes 2 No PRINCE WILLIAMS WOODBRIDGE hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22193 4570 PERCH BRANCH WAY USA Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married _ _NARMY X Yes es, Give Yea 3 Widowed Divorced 1 Yes 2 X No specify: Specify: BLACK ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 PRIVATE 2 yrs ELECTRICIAN 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN ROBIN EDWARDS ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 829 FARAWAY COURT MITCHELLVILLE, MARYLAND 20721 ROBIN LOVELL/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) 4/19/2008 HARMONY CEMETERY LANDOVER, MARYLAND Other Specify: Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 239 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - tran Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760, IE EEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Other-ER/Outpatient DOA Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 3 1 V Yes No 28a. Date of Injury 28d. Describe how injury occurred Driver auto fixed object collision 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: Apr 12, 2008 0411 hrs 1 Natural Yes 2 V No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) W/B Rt. 214 , Bowie , MD determined

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Director: completely filled in by

4

Medical

State

Margarita Korell MD. 31. Date filed (Month, Day, Yea

29b. Signature and title of certifie

Mulyoute

Homicide 29a. Certifier 1

> Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signa

(Specify) Local Street

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Registrar

29d. Date signed (Month, Day, Year)

April 12, 2008

			1 - For State Registrar	State of	•	epartment Certificate			nd Mental Hyg	iene eg. No.	08	14148
ı	Physici		Decedent's Name (First, Middle, Last) CATHERINE CREEL I	יכידבט					2. Date of Dea Month APRIL	Day	Year 12	3. Time of Death 1:32 PM M
7	/Medic Examir		4a. Facility Name (If not institution, give		per)	4b. City, T	own, or	Location of			y of Death	1.52 FM
			ATLANTIC GENERAL	HOSPITA	L_	BER					CESTER	L
	Funeral Director		379-30-3303	7]M 2 X F	. Age (In yrs. last birth	rs. If Under 1	Year Days	Hours	8. Date of Birth Min. NOV • 10	Year) 1928	Coun	place (State or Foreign http) IINGTON, DC
	land wow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
	•-fah	ctor	MARYLAND WORCESTE	R	OCE	AN CITY						1 Yes XXNo
	ith the	Director	10e. Street and Number			10f. Zip (0g. Citizen of		niry?
	e 23e		3110 SKIPJACK LAND		ent Ever in U.S.		842	nania Osia	jin? (Specify Yes or No-	U.S.A.	ice - Americ	ean Indian
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or itame 23s or 28e-1 ahow other traumatic avent, the Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? X No	If Yes, special	fy Cubar	n, Mexican	Puerto Rican, etc.)	Bla	ack, White,	etc.
5-0	"natur	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)		Decedent's Usual 'Give kind of work life. DO NOT use	done di	uring most	of working	16b. Kind of E	Business/In	dustry
12	l withir	omp	Elementary/Secondary (0-12)	College (1-4	for 5+)	HOME				OWN	HOME	
Maryland 21215-0036	2 should be filed and Mental Hygi is markad other aumatic avent,	To Be C	17. Father's Name (First, Middle, Last) OSWALD HARRIS						r's Name (First, Middle,	Maiden Suma	me)	
Mary	trauma		19a. Informant's Name/Relationship (Ty JAMES ESTEP — SON	pe, Print)		_			r or Rural Route Numbe			
altimore,	0 0 = =		20a. Method of Disposition 1 Rurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from SI	20b. Place of late QUAN	Disposition (Name of National CEMETERY	e of	2h	Date AY 1, 2008	20c. Location	- City or To	
Balti	permit. Pag Depertment important: i any injury o		21. Signature of Funeral Service Licens	Cle	/	22. Name and			MOUNTCASTLE DALE CITY			
	Physician /Medical		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cations that can no cause on ear Me	used the death. Do no ch line. tastatie		,		cardiac or respiratory are			Approximate Interval Between Onset and Death
8760,	eate be executed by sicien and the burial-transit and	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequence of	Ŋ.						
O. Box 6	The law requires thet the death certifica tie has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ★Unknown	1 Live bin	ome of pregnancy th 2 ☐ Fetal death nt at time of death vn	3 □Ectopic pre 5 □ Other (spe					ate of delive	ery Day Year
rds, P	quires thet in signed b uld be deta	٥	Part II. Other significant conditions con	à	ith but not resulting in	- Ai	use give	n in Part I.		bacco use col	ntribute to th	ne cause of death?
Record	The law requir ate has been si page 2 should	Completed		· · · · · · · · · · · · · · · · · · ·					24a. Was a autop perfor	sy	. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of
Vital	cian: ertific ector,	Be	25. Was case referred to medical examiner?	l last.			Tax		of Death Check only or	10)		
on of \	Attending Physician: r death. sctor; After this certifica	lon: To	27. Manner of Death 1 DNatural 5 Pending	28a. Date of	Injury 28b. Ti		c. Injury Work	at A LINU	rsing Home 5 Aesid			(y)
Division of		Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	f Injury - At home, fari g, etc. (Specify)					treet and Nun n, State)	nber or Rura	al Route Number,
	To the Hospital or within 24 hours effer To the Funarel Dircompletely filled in In	Medical C	29a. Certifier 1 Certifying Physical Control one) 1 Medical Exami	sician: To the base ner: On the base and manne	is of examination and	death occurred a /or investigation,	t the tim	e, date and inion, deat	d place, and due to the d th occurred at the time, d	ause(s) and n late and place	nanner as s o, and due to	tated. the cause(s)
	To the Ho within 24 To the Fu completel	Z	29b. Signature and title of certifier	/	-	29c.	License	number		29d. Date sign	ed (Month,	Day, Year)
ı			4/1/our	w		> 6	77	826	9	4/2	1210	08
			30. Name and address of person who co	Impleted cause		Type, Print)	-	1 1	. Fo.	h	Selo.	1 De lazion
	Sta Registi		31. Date filed (Month, Day, Year) APR 3 0 20	- (gistrar's Signature	March 5	->04	<i>y u</i> '	Juney 1 de		- pulle	1 1000

DHMH 17 Rev 1/2001

Catherine C ESTEP DUB 11/16/1528 579-30-5505 DUDY-21-2008 (1332)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ALICE FRAY APRIL 11 2008 1645 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL P.G. TAKOMA PARK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F NEW YORK 115 22 5614 87 Director 1921 MARCH 21 Usual Residence of Decedent within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 Yes 2 No Director MD. P.G. MT. RAINIER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3001 UPSHUR STREET 20712 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify BLACK 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT CLERK the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H important: If Item 27 is marked oth any Injury or other traumatic even Be BENJAMIN FRAY MARIE MONROE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRY FRANCIS/SON 3001 UPSHUR ST., MT RAINIER MD. 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State | Departion | 5 | Other (Specify) | RIVERDALE PK CREMATORY 4/16/08 RIVERDALE MD. 22. Name and Address of Facility WATSON F. H. 21. Signature of Funeral Service Licensee 3435 14th ST., N.W. WASH. DC. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE **Physician** /Medical Due to (or as a consequence of) Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence oi). death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1∐ Yes 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 AER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registra

RAYĮ PASSI MD 15225 SHADY GROVE RD. #208 ROCKVILLE, MD. 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 **APR 1 6**



D 28656

APRIL 15, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 April 2, 12:10am M James Earl Foreman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1X□M 2□F Walstonburg, NC 11/1/1925 Director 82 240-44-2286 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show ä be notified X Yes 2 No Director Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 'natural', or items 23a dical Examiner must b 10802 Cheryl Turn 20603 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: Black þ 3 ☐ Widowed 4 ₺ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Supervisor US Government 12 should be filed w h and Mental Hygiel 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lloyd Foreman SR. Della Maye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important; If Item 27 is any Injury or other trau 10802 Cheryl Turn Waldorf, Maryland 20603 <u>Geraldine Foreman Law/ Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/2008 4 □ Donation 5 □ Other (Specify) Cheltenham, Maryland Maryland Veterans 21. Signature of Funeral Service Lice 22. Name and Address of FacilitPope Funeral Homes, P.A. MU108 5538 Marlboro Pike Forestville, Maryland 20747 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Pard. Enter the disea shock, or heart failure Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequate of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consection of affi Examiner certificate be executed burial-transi Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown signed by the aid be detached for 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy perform certificate 1□ Yes 2 PNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury spital or Attendin nours after death. Ineral Director: A' 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital

29a. Certifier

(Check only one)

29b. Signature and titly

Medical

and manner stated.

29c. License number 10055120

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

17pm | 2nd 2008

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

ramer mD 1328 Southern avoning SE Just 310 ^{Yea}2008

State Registra

		•	For State of Maryla 1 - State Registrar	-	rtificate of			- 211112	3 14151
			Decedent's Name (First, Middle, Last)		Timoato or	Dourn	2. Date of Deal		3. Time of Death
F	hysicia Medic		Jorge Alberto Frumento				Month April 1	Day Year 5. 2008	4 - 00 M
A. Maria	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Deat		4c. County of Dea	4:09 a
a pr			10015 Grayson Avenue		Silver	Spring		Monte	gomery
	uneral irector		270 40 T455 1X14 2□ E	rs. last birthday) 31 Yrs.	Months Days	Hours Min.	(Month, Day	Year) 9. Bii	thplace (State or Foreign ountry)
	rector		Usual Residence of Decedent	, <u>r</u>			July 12,	1926 AF	gentina
ryland	how		10a. State 10b. County 10c.	City, Town or Lo	cation				10d. Inside City Limits
е Ма	Ba-f s	Director	Maryland Montgomery	Silv	er Sprin	g			1 □Yes X□No
h with th	23a or 2 st be no	al Dire	100 15 Grayson Avenue		10f. Zip Code 20901		1	0g. Citizen of What C USA	ountry?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Micical Executive must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 【 No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba	an, Mexican, Puer	Specify Yes or No- to Rican, etc.) rgentinia	14. Race - Am Black, Whi	te, etc.
21215-0036 d within 72 hours aft giene.	than "natura ne Wedical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4	(Give	dent's Usual Occup kind of work done DO NOT use retired sulting En	during most of wo d)	rking	16b. Kind of Business	
Hydi G	other ent,		17. Father's Name (First, Middle, Last)	COIIS	dicing E		me (First, Middle, i	vil Engine Maiden Surname)	eering
lan lid be fental	rked c	To Be	Jose Frumento			Bella	Milano		
Maryland of 2 should be file lith and Mental Hy	is ma		19a. Informant's Name/Relationship (Type. Print)		-			r, Cify or Town, State,	
and and lealth	m 27 her tr		Elisa Leonor Frumento/Wife						g, MD 20901
altimore, rmit. Pages 1 ar	nt; If ite ry or ot		1 Burial 2 Coremation 3 Removal from State	-	osition (Name of matory or other place itan Cren		rii is,	20c. Location - City of exandria,	
Balti permit. Departn	Importa any Inju once.		21. Signatur of Funeral Service Licensee	22 F	2. Name and Addre	ss of Facility Collins	s Funeral	Home Inc.	
			23a. Part 1. Enter the disease, or complications that caused the de						ng, MD 20901 Approximate
Phys	sician		shock, or heart failure. List only one cause on each line.						Interval Between Onset and Death
-	edical		disease or condition resulting in death) a. Due to (or as a cons		ase				0 Years
Exa	miner		Convention link and divine						
P	##	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	equence of):					
xecute	and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last	oguenos of):					
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687 tificate	g phy as the	edical	d						
. 0	by the attending lached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of the	etal death 3	☐ Ectopic pregnand ☐ Other (specify) _	ey		23d. Date of de Month	elivery Day Year
<u>ت</u> —	signed by		Part II. Other significant conditions contributing to death but not	esulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
rds quires	should be	ed by					407	es 2 □ No 3 □ F	Probably 4 TXUnknown
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	has le 2	m M					24a. Was a	sy prior to	utopsy findings available completion of cause of
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on of Vital Records, P.O ling Physician: The law requires that the 	this certificate has al director, page 2	Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 27. Manner of Death ★① Natural 5 ☐ Pending (Month, Day, Year)	28b. Time o	f 28c. Injui	ler: 4 ☐ Nursing I ry at k?	24a. Was a autops perfor 1 □ Yes ath (Check only or Home 5 🙀 Resid	sy prior to med? death? 2 ☑No 1 ☐ Ye	utopsy findings available completion of cause of s 2 □ No
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	/Medio Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	III KIL	4c. County of	
	_Adiiiii		St. Mary's Hos	pital		Leona	rdtown		St. Ma	ry's
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreig Country)
-pid	Director		226-02-1095 Usual Residence of Decedent		42 Yrs.			5-11-19	55	Virginia
	yland low at		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit
	a-f sh	ctor	Maryland St. Ma	ry's		Hollywood				1 □ Yes 2X N
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?
	ath w	ral	24790 Barbara L				636		United S	
	er des items ner m	Funeral	11. Marital Status 1 ☐ Never Married 2 [X Married]	12. Was Decedent B Armed Forces? 1 ☐ Yes 2X N	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec ın, Mexican, Puerto R	ify Yes or No- ican, etc.)		American Indian, White, etc.
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	40	1 ☐ Yes 2 ☐XNo	Specify:		Specify:	White
21215-0036	2 hou atura cal E	ted	15. Decedent's E	ducation (16a. Dece	dent's Usual Occup	ation	I	16b. Kind of Busi	ness/Industry
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Σ	hould d Mei marke	2	Edward Scott Gr 19a. Informant's Name/Relationship		19h Maili	ng Address (Street a	Nan Lue and Number or Rural		City or Town S	tate Zin Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Joseph P. Fay /			-	Lane, Ho		-	
	s 1 ar f Hea item other	1	20a. Method of Disposition			osition (Name of matory or other place				ity or Town, State
Baltimore,	Page ient o nt: If ry or		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		Riverside		1	2008	Courtlar	d, Virginia
alti	permit. Departm Importa any Inju		21. Signature of Funeral Service Lice	Dee /					Funeral	Home, P.A.
<u> </u>	e a E e		Edward W. Brinsii							MD 20650-027
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en ne.	ter the mode of dyin	ig, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	ulmoner	embo	letm			
	/Medical Examiner			Due to (or as	a consequence of):					
1 160		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	en 100	unery-			
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Вох	death c e attenced for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	□Ectopic pregnancy	1		23d. Date Mon	of delivery th Day Year
o.	the de y the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time or death 3					
₫.	that ed b deta	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	acco use contrit	oute to the cause of death?
√rds	quires n sign							1 □ Ye	es 2□No :	B□ Probably 42 Unknow
FAY ecords,	sician: The law requires certificate has been sign rector, page 2 should be	Completed						24a. Was a	n 24b. W	ere autopsy findings availat ior to completion of cause o
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<u></u>	ding Phys h. After this funeral di	i.i.o	27. Man r of Death Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	Wor	yat k? Yes 2 □No	8d. Describe ho	w injury occurre	d
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NATALIE (Division	al or Attendlis after death.	ertification:	4 ☐ Homicide determined	building, et	c. (Specify)			City or Town	n, State)	
NA	spita nours neral	O		hysician: To the best						
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 ☐ Medical Exa	miner: On the basis o and manner st	of examination and/or i ated.	nvestigation, in my o	opinion, death occurre	ed at the time, o	late and place, a	nd due to the cause(s)
	To the within To the comple	Ž	29b. Signature and title of certifier		,	29c. Licens	e number	2	. /	(Month, Day, Year)

29c. License number 028821 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

navaleun md, 20650

JAMUS

State Registrar

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	45	Registrar 1. Decedent's Nam	ne (First, Middle, L	ast)			Ue.	lillicat	e 01 1	Dealli	2. Date of D	Reg. Ne	·200	3	3. Time of Death
Physicia /Medic		Raymono	d Le	ee	Fer	rel1					APRIL	21	2008		3:55p ^M
Examin		4a. Facility Name (I	If not institution, g	ive street a	nd number)			4b. City,	Town, o	r Location of Death	1	40	c. County of De	ath	<u>-</u>
		St. Man 5. Social Security N	ry's Hos	oital Sex	7 Δα	e /In vre	last birthday)	If Under		rdtown If Under 24 Hrs.	8. Date of B	inth	St. Ma		
Funeral Director		346-26-22		1 X M 2[74	Yrs.	Months	Days	Hours Min.	3-30-1	ay, Year) (Ocuntry)	
pu »		Usual Residence of	f Decedent				, Town or Lo				13 30 1	. , , , ,			
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th witi 23a o ust be		45252 E	Elmbrook	Drive	<u> </u>				2061	9		τ	nited :	Stat	es
er dea Items	Funeral	11. Marital Status		Arm	Decedent ned Forces?		S. 13.			lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)		14. Race - Ar Black, Wi	nerican	Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by F	1 □ Never Marr 3 □ Widowed	ried 2 Married 4 Divorced	If Y	Yes 2□ es, Give r or Dates:	No		1 ☐ Yes	2XNo	Specify:			Specify:	Whit	e
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2 shot and N Is mai		19a. Informant's N	ame/Relationship	(Type. Prir	nt)		19b. Maili	ng Address	(Street	and Number or Ru			or Town, State	, Zip Co	ode)
and 2 lealth m 27		Helen W.		_ / Wi	fe	T	45252	E1mb	rook	Drive,					
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permi Depar Impor any Ir		Edward N.	1/1/1	1	Jr.	M0005				^{ss of Facility} Br ywood Rd					
1	25	23a. Part1. Enter t shock, or hea						ter the mod	le of dyir	ng, such as cardiac	or respiratory	arrest,	Own, In	Ar	pproximate terval Between
Physician		Immediate Cause disease or condition	(Final	,	REST	IRA	TORY	FAI	LUI	et				Ö	nset and Death
/Medical Examiner		resulting in death)	- 6	D	ue to (or as	a consequ	uence of):	e_1 /	,	11104				1	0.
	e	Sequentially list confiant, leading to in cause. Enter Under	onditions,	b	ue to (or as	a consequ	uence of).	TTIN		10,0129				· ·	7375
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be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):												1	
	dical	d													
The law requires that the death certificate be exate has been signed by the attending physician bage 2 should be detached for use as the buna	Physician/Medi	IF FEMALE:		23c, If ve	es, outcome	of pregna	ncv						00d Data of		
death e atter d for u	iciar	23b. Was deceden in the past 12 1 □ Yes 2 [months?	1 □ 4 <u>□</u>	Live birth Pregnant a	2 Feta	I death 3	⊒Ectopic p ⊒Other <i>(sp</i>		/		1	23d. Date of o Month	Da	ay Year
that the de ned by the a detached f	hys	9 ☐ Unknown		9Ĺ	Unknown										
aw requires that s been signed to should be deta	by	Part II. Other signi													cause of death?
requi	Completed			- 47	0.02	^	12001	11-	1 5		11	Yes 2	2 No 3 No	Probabl	ly 4 donknown
s iclan: The law certificate has t irector, page 2 s	Jdm.			70,0	4	1701	10001	177	CA	7		s an opsy formed?	24b. Were prior t death	o compl	/ findings available letion of cause of
an: Ti tificate or, pa		25. Was case refer	rred to medical	T						26. Place of Dea	1∐ Yes	2 N			□ No
nysicia nis cer direct	To Be	examiner? 1 ☐ Yes 2 ☐		Hospital	1. Impation	ent 2	ER/Outpatier	nt 3 □ DC	Oth	er.	lome 5 ☐ Re		6 □Other (Si	necify)	
Ing Pt		27. Manner of Deat	th 5 🗆 Pendina	28a.	Date of Inju		28b. Time o	of 2	8c. Injur Wor		28d. Describe				
ttend death. stor: /	icati	2 ☐ Accident 3 ☐ Suicide	investigati 6 ☐ Could not	be 380	Place of ini	un. At bo	me, farm, st	M factor		Yes 2 □ No	206 1	(0)	and Advantage	D / O	
after all or A	Certification:	4 ☐ Homicide	determine	d 200.	building, et	c. (Specify	/)	reet, ractory	, once		City or T		ind Number or te)	Hurai H	oute Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only	1 Certifying F	hysician:	To the best	of my kno	wledge, deat	h occurred	at the tir	me, date and place	e, and due to th	e cause(s) and manner	as state	∍d.
the Ho nin 24 the Fu	Medical	one)		aminer: Or an	the basis of manner st	ated.	tion and/or ir			ppinion, death occu	urred at the time	e, date a	nd place, and c	lue to th	e cause(s)
Vity Vity Con Con	2	29b. Signature and	title of certifier				s. 71.			e number			ate signed (Mo		
1.		20 Name 2 1	1000	0.00==-1-1	d on :== : f :	le ath- O	MS	Dule A	1150	3096		4	1-22-	- CO &	
~ 20°		30. Name and add	DB1 ND	S complete		leath (Item	- ST	AH .	ASSO	CANTEC	na	Lyw	500	ME	20636
Sta		31. Date filed (Mon			32. gistr	ar's Signa	ture	1 5	_			, -			
Registr	ar	<u>"</u>	1PR 23	2008	But	ار معا	5 A		7						

22. Name and Address of Facility

enter the mode of dying, such as cardiac or respiratory arrest,

Physician /Medical **Examiner**

The law requires that the death certificate be executed

Box 68760

P.0.

Division or Vital Records,

or Attending Physician:

physician ar

certificate ha

after death | Director: , d in by the f

Immediate Cause (Final disease or condition resulting in death) Dementia Due to (or as a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Coronary artery disease Diabetes Hypertension 25. Was case referred to medical Be examiner? Hospital: Other: 4x Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation 1 Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1∐ Yes 2 No 26. Place of Death (Check only one)

Tyrone J. Young 719 Kennedy Street NW Wash

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4/10/2008

29d. Date signed (Month, Day, Year)

DC 20011

Approximate Interval Between Onset and Death

within 24 hours a

To the Funeral I

completely filled State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ghousia Sultana 12107 Heritage Park Cir. Silver Spring, MD 20906

31. Date filed (Month, Day, Year) APR 1 6 2008

29b. Signature and title of certifier

21. Signature of Funeral Service Licensee

23a. Part1. Enter the disease, or complication shock, or heart failure. List only on



Registrar

29c. License number

D56691

08-02617 Tro

oy A. Gordon	State of Maryland / Departmer 1-For State Registrar Amend#2PerPhysPGC4/11/0ertificate		ygierie	0000 1115
Physician/		e or Death	Reg. No. 2. Date of Death	3. Time of Death
edical Examine	Troy A. Gordon		Month Day March 2, 2008	4/2708 2104 hrs
	Facility Name (if not institution, give street and number) S652 Whitfield Chapel Road	4b. City, Town, or Location of Death Lanham		County of Death ince George's
Funeral	Social Security Number 6. Sex 7. Age (In yrs, last birthda)			D/YYYY) 9. Birthplace (State or
Director	216-88-7633 1 _x M ² F 31	Yrs. Months Days Hours Min	January 12.	Foreign Country 1977 Maryland
	Usual Residence of Decedent		T. HITHLY 1/2,	,
low any				10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f show Lifted at once. Director	Maryland Prince George's J: 10e. Street and Number	10f. Zip Code	10g. Citize	en of What Country?
the Man or 23 tiffied.	8735 Contee Road #301	20708	τ	J.S.A.
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fish comatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. 1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		Race - American Indian, Black, White, etc.
er deal	1 Yes 2 X No	1 Yes 2 No specify:	,	
ours after a trural" amine	Lor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. De	cedent's Usual Occupation (Give kind of	work done 16b. Kir	pecify: Black nd of Business/Industry
136 hin 72 hc e. than "na edical Ex	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use ret	ired)	
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exar	12th grade Sto	ock Clerk	- Wal- e (First, Middle, Maiden S	-Mart Stores
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple	Willie C. Moore	1	Deborah G. Gor	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filled with Department of Health and Mental Hygiene. Important: If item 27 is marked other tiniury or other traumantic event, the Med To Be Comi		Mailing Address (Street and Number or	•	· · · · · · · · · · · · · · · · · · ·
MD 2 shot all the modern and 2 shot and 2 shot and 27 is raumati		735 Contree Road #301 Law Disposition (Name of cemetery,	rel, Maryland	20708 ocation - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	1 X Burial 2 Cremation 3 Removal from State Lincoln	or other place) Amorial Cemetery April	1 10. 2008 Suit	-land Maryland
nit. Pa artmen oortand ry or c	4 Donation 5 Other Specify: 21 Signature of Juneral Service Licensee	22. Name and Address of Facility Ro		
Ba Pern Dep Inju	Just C. Inderson	4339 Hunt Place, N.E. V	Washington, D.(C. 20019
Physician /Medical	234 Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest, shoo	k, or heart Approximate interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Head Due to (or as a consequence of):			Death
	Sequentially list conditions, b			
iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
xecuted n and - transit	d. UNPENDED AMENDED			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transcompleted by Physician/Medical E.	IF FEMALE: 23c. If yes, outcome of pregnancy		23d	. Date of delivery
30x 6876 Jeath certificate e attending phy for use as the ysician/M	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregn		Month Day Year
Box e death c the attent ed for us	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)		3
O. Bo at the de d by the stached f	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
S, P.(Lires tha a signed d be det			1 Yes 2 🗸	No 3 Probably 4 Unknown
Records, The law require: ficate has been sig. page 2 should be			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			performed? 1 ✓ Yes 2 No	death? 1 Yes 2 No
of Vital ng Physician: After this certi neral director	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outs	26.Place of Death (Check patient 3 DOA Other Nursi		nce 6 🗸 Other: Scene
Sion of Vital Attending Physician: rdeath. ector: After this certif by the funeral director. cation: To Be (27. Manner of Death 28a. Date of Injury 28b. Tin	ne of Injury 28c. Injury at Work?	28d. Describe how injur	
ion tendir eath. tor: A the fu	1 Natural 5 Pending FOUND: Day, Year) 2 Accident Investigation Apr 2, 2008 FOUND		Subject shot	
E	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	n, street, factory, office building, etc.		nd Number or Rural Route Number, City el Road, Lanham, MD
	29a. Certifier 1 Continue Physician To the heat of my land day doubt	provinced at the time date and place an	1	
To the Ho within 24 To the Fu completely	Check only 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or involutional manual manu			
To with To con	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
	Calmer 17.	O.C.M.E.	April	3, 2008
\	Name and eddress of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111	Penn Street, Baltimore, MD 2	1201	
State		and others, baltimore, IVID 2	-	
Registra	31. Date filed (Month, Day Year)		OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician
/Medical
Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Yo the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

an	1. Decedent's Name (First, Middle, Last) Milton 0. Gustaf	son	April 12, 2008	6:20A M
cal ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of D	eath
	2706 Shawn Court	Fort Washington If Under 1 Year If Under 24 Hrs.	Prince 8. Date of Birth 9.1	
	5. Social Security Number 477-38-3020 6. Sex 1 M 2 I F 68 7. Age (In yrs. last birthday,	Months Days Hours Min.	(Month Day Year)	Birthplace (State or Foreign Country) Lnnesota
	Usual Residence of Decedent			
7	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ecto	Maryland Prince George Fort Wash	hington 10f. Zip Code	10g. Citizen of What	
Ö	2706 Shawn Court	20744	USA	
nera		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	merican Indian, /hite, etc.
Be Completed by Funeral Director	1 ☐ Never Married 2 M Married 1 ☐ Yes 2 M No If Yes, Give	1 ☐ Yes 2 No Specify:	0.574	White
ed b	15 Decedent's Education 16a, Dece	edent's Usual Occupation	16b. Kind of Busine	
plet	(Specify only highest grade completed) (Given life.	e kind of work done during most of work DO NOT use retired)		,
Com	5+ Dipl	omatic Historian		Government
Be	17. Father's Name (<i>First, Middle, Last</i>) Otto Leonard Gustafson		ne (First, Middle, Maiden Surname) Eleanor Rundquist	-
은		ling Address (Street and Number or Ru	<u></u>	
		Shawn Court Fort		
	20a. Method of Disposition 1 ☐ Burial 2 【XICremation 3 ☐ Removal from State 20b. Place of Disposerery, creation 2 1 ☐ Burial 2 【XICREMATION 3 ☐ Removal from State 2 ☐ XICREMATION 2 ☐ XICREM	ematory or other place)	Date 20c. Location - City	
	4 □ Donation 5 □ Other (Specify) / Kalas Cr		3/2008 Edgewater	
	. # // // /	22. Name and Address of Facility ${\sf Geo}$	_	
	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
				Onset and Death
	disease or condition resulting in death) Due to (or as a consequence of):	9-2001113		
Į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b			
m in	cause. Enter Underlying Cause (Disease or injury that initiated events C			
ician/Medical Examiner	resulting in death) Last Due to (or as a consequence of):			
dice	d			
an/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of	•
sicie		Other (specify)	Month	Day Year
Physi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribut	te to the cause of death?
Completed by			1 Yes 2 No 3] Probably 4 ∰Unknown
plet			autopsy prior	e autopsy findings available to completion of cause of
			performed? deat 1 Yes 2 No 1 □	h?
Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other	ath (Check only one)	
7: 70	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	lome 5 Residence 6 Other (3 28d. Describe how injury occurred	Specify)
atio	1 X Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No		
rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street and Number o City or Town, State)	r Rural Route Number,
Medical Certification:	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	and due to the cause(s) and manne	er as stated.
edic	(Check only 2 Medical Examiner: On the basis of examination and/or one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (N 7 3 3 411216	
2	30. Name and address of person who completed cause of death (Item 23a) (Type		1112/0	- 3
	AJ: T AHLUWAUA, 4715 NISM	ST, ARLINGTON	VA 22205	
ate	31. Date filed (Month, Day, Year) APR 1 1 2008 32. Registrar's Signature			
rar	MILL TO THE PARTY OF THE PARTY			

DHMH 17 Rev 1/2001

Registrar

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic events.

use as t certificate has b irector, page 2 sl

Division or Vital Records, P.O. Box 68760,

4 Donation 5 Other (Specify	nt. OII	ver cemerer	2008	'	J	, 50
21. Signature of Funeral Service Licen	see	22. Name and Address of	Facility Stev	vart Fune	eral Home	e, Inc.
John J.	Stowart, III	4001 Bennir	ig Road, N	NE Washir	ngton, Do	20019
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused the death. Do not enone cause on each line.		uch as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
disease or condition resulting in death)	a Cerebrovascular	Accident				5 months
resulting in death)	Due to (or as a consequence of):					
Comment that the distance of the comment	h					
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):					
Cause (Disease or injury					. 1	
that initiated events resulting in death) Last	Due to (or as a consequence of):					
	.d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 ②No 9 □ Unknown		☐Ectopic pregnancy ☐ Other (specify)			23d. Date of del Month	ivery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given i	Part I.	23e. Did tobacco	use contribute to	the cause of death?
	ure to Thrive	,,				robably 4 □Unknown
	0.00 0.			1 🗔 163	242 110 5 11	ODADIY 4 DOTKIOWII
				24a. Was an autopsy performed? 1 Yes 2 🕅 t	24b. Were au prior to death? No 1 □ Yes	utopsy findings available completion of cause of
25. Was case referred to medical		26	i. Place of Death (C			
examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othory	4 ☐ Nursing Home		6 Dott (0	-26.3
27. Manner of Death	28a. Date of Injury 28b. Time			. Describe how in		спу)
1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work?	2 □ No	. Describe flow iti	ary occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f.	Location (Street City or Town, Sta	and Number or Ri ate)	ural Route Number,
29a. Certifier (Check only one) 1XXCertifying Ph 2 Medical Exam	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or and manner stated.	ath occurred at the time, investigation, in my opin	date and place, and on, death occurred	I due to the cause at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
29b. Signature and title of certifier		29c. License nu	mber	29d. D	Date signed (Mont	h, Day, Year)
D 8/4	Mahew	D	47600	+ 0	4/15/2	008
30. Name and address of person who	completed cause of death (Item 23a) (Type	Print)				

State

Registrar

Sobhan A. Mathew,

31. Date filed (Month, Day, Year)

APR 1 7 2008

M.D.

3048 Mitchellville Road - Bowie, MD 20716

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For 1 _ State	State of	of Marylan		artment of F				00	0	11.150
		Registrar 1. Decedent's Name (First, Middle, I	acti		Cei	illicate of	Dealli		2. Date of Death	g. No.	UÜ	3. Time of Death
Physicia	ın			1 0-14-					Month	Day	Year	12:19 a M
/Medic		4a. Facility Name (If not institution, g	nia Gonza		na	4b. City, Town, o	r Location	of Death	April	14 4c. County	of Death	
Examin	er	4403 Independence		iniber/			Rockvi			i.e. county		gomery
Funeval			Sex	7. Age (In yrs.	last birthdav)	if Under 1 Year	If Under		8. Date of Birth			lace (State or Foreign
Funeral Director		577-11-9619	1 ☐ M 2 🗷 F	58	34	Months Days	Hours	Min.	(Month, Day, January 2.	Year) 3.1950	Cour	Peru
them (A)		Usual Residence of Decedent							,	,		
yland Iow		10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
Mar a-f st	형	Maryland Montgo	omery			R	ockvi1	1e				1 X Yes 2 ☐ No
r 28g	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	Vhat Coun	itry?
death with the Maryland rms 23a or 28a-f show rmust be notified at		4403 Independence	Street				20853	3	ì	U	.S.A.	
deat ms 2	Funeral	11. Marital Status		edent Ever in U.	.S. 13.	Was Decedent of H	lispanic Or	rigin? (Spe	cify Yes or No-		e - Americ	
after or ite		1 X Never Married 2 ☐ Married		2 🕱 No		1 X Yes 2 No	Specify:		nican, etc.)		k, White,	etc.
ours rai", Exa	i by	3 ☐ Widowed 4 ☐ Divorced	Year or D	Dates:		TES ZEINO	эреспу.	Per	ruvian	Specify	:	White
72 hc natu dical	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occup kind of work done	ation during mos	st of workir	na 1	16b. Kind of Bu	isiness/Ind	dustry
thin te.	ם	Elementary/Secondary (0-12)		1-4or 5+)	`life.	DO NOT use retired	d)					
ed w ygier ver th	දු	12				House	keeper				omesti	ic
be fill d oth even	Be	17. Father's Name (First, Middle, La							(First, Middle, N		•	
ould Men arke	2	Nicolas Gonzales							cundina S			
2 sh and is m		19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Numb	er or Rura	l Route Number,	City or Town,	State, Zip	Code)
and lealth m 27 her t		Ruth Pozas - Si	ster	201- 5		Independen	ce Str					
ges 1 t of H if ite or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from		emetery, cre	osition (Name of matory or other plac	ce)	U	ate 2	20c. Location -	City or To	own, State
men men tant: lury		4 ☐ Donation 5 ☐ Other (Spe	cify)		te of He	eaven Cemet	ery	04/19	/2008	Silver S	Spring	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee	, -	2:	2. Name and Addre H ines-Rinal	ss of Facili	ity eral H	lome. Inc.			
20 E # 9		umanda	Tuc	dewig	/	11800 New H	ampshi	re Ave	nue, Silv		g, Mar	yland 20904
		23a. Part1. Enter the disease, or co shock, or heart failure. List of	mplications that	caused the dwall each line.	h. Do not en	ter the mode of dyir	ng, such as	s cardiac o	r respiratory arre	est,		Approximate Interval Between
Physician		immediate Cause (Final disease or condition	Meta	static So	ft Tiss	ue Sarcoma						Onset and Death 6 years
/Medical		resulting in death)	Due to	(or as a conseq	uence of):							
Examiner		Sequentially list conditions,	b									
p #	ner	if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	Due to	(or as a conseq	uence of):							
nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
e exe ian a urial-		resulting in death) cast	Due to	(or as a conseq	uence of):							
The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dical		d									
ertific ing p	Med	IF FEMALE:										
eath certific attending p for use as	an/	23b. Was decedent pregnant in the past 12 months?		itcome pf pregna birth 2 ☐ Feta		Ectopic pregnancy	,			23d. Dat Mo	e of delive	ery Day Year
he al	sici	1 ☐ Yes 2 🗷 No	4□Preg 9□Unkr	nant at time of d	eath 5	Other (specify)				WIO	iiui	Day Teal
that the denet of the stacked	Physician/Me	9 Unknown			w				00 01111			41
res the igner	þ	Part II. Other significant conditions	s contributing to o	leath but not resi	uning in the a	ndenying cause giv	en in Part	1.				ne cause of death?
w require been si should t	ted								1 Ye	s 2 K]No	3 Prob	ably 4 Unknown
has be	ble								24a. Was an	24b. \	Nere auto	psy findings available mpletion of cause of
	Completed								perform 1 Yes 2	red?	death?	2 □ No
sician: The certificate h irector, page	Be (25. Was case referred to medical examiner?					26. Place	e of Death	(Check only one	9)		
Physic this ce al dire	2	1 ☐ Yes 2 🔀 No	Hospital: 1 □	Inpatient 2□	ER/Outpatier	nt 3□ DOA Oth	er: 4□ Ni	ursing Hon	ne 5 🗷 Reside	nce 6 □Oth	er (Specif	y)
6 e e		27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at k?	2	8d. Describe ho	w injury occurr	ed	
endi	äţic	2 ☐ Accident investigat					Yes 2□]No				
ier de lirect	≝∣	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	Zoe. Place	e of injury - At ho ling, etc. (Specif	ome, farm, str	reet, factory, office		2	28f. Location (Str City or Town		er or Rura	I Route Number,
ital c rs aff ral D led ir	Certification:											
	edical	(Check only 2 Medical Ex	aminer: On the b	pasis of examina		h occurred at the till vestigation, in my o						
the hin 24	led	one)	end mar	ner stated.	/ /							
vit To To	Σ	29b. Signature and title of certifier	11/1/8	11.11	1	29c. Licens	e number		29	od. Date signed	(Month,	pay, Year)
3		VWWMW	AH	Mer	W	D	C10200)		7/1	5/1	08
		30. Name and address of person wh	o completed cau	se of death (Item	1 23a) (Type,	Print)				1	1	
		Dennis A. Prieb				t, NW, Suit	e C-21	L51, Wa	ashington,	DC 200	10-297	75
Star Registra	_	APR 1 6 20	108	Registrar's Signa	iture A	all a						
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			For			d / Depa	rtment of H	ealth and	-	giene	008	11.159
			1 - State Registrar			Cer	tificate of L	Death		Reg. No.	.000	1 44 1 0 2
8	Physici	an	Decedent's Name (First, Middle			_			2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Sanford		mer	Gr	iffith 4b. City, Town, or	Location of Doo			2008 County of Death	21:35P M
	Examin	er	4a. Facility Name (If not institution,		umber)		Elkt		uri		Cecil	
	Funeral		Sunbridge C 5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	1	O. Dish	place (State or Foreign
	Director		222-18-2203	1∏M 2□F	82	Yrs.	Months Days	Hours Min	oct.	20,1	925 _{Pen}	nsylvania
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation					IOd. Inside City Limits
	Maryla f eho	ō		.		ewisv						1 ☐ Yes 2 🙀 No
	28a-	Director	PA Ches 10e. Street and Number	cer		CWIDV.	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at	O IE	2651 Lewisvi	lle-Oxf	ord Ro	ad	193	51			USA	
		Funeral	11. Marital Status	12. Was De	cedent Ever in U.	S. 13. V	Vas Decedent of H	spanic Origin? (Specify Yes or No	- 1	4. Race - Americ Black, White,	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	11 (45, 0			I □ Yes 🏋 No	Specify:			Specify: Wh	ite
21215-0036	within 72 hours after death with the Marylan ene. than "natural", or Itema 23a or 28a-1 ehow he Madical Examiner must be notified at	ed b	15. Decedent	Year or	Dates:	16a, Deced	lent's Usual Occup	ation		16b. Kin	nd of Business/In	dustry
212	nin 72 In "ne Media	piet	(Specify only highes Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	(Give	kind of work done of OO NOT use retired	during most of wo	orking			
21	giene gritha	Completed	12	Conego	(1 401 01)	Plu	mbing Co	ontract	or	Pl	umbing	
ם	be filed within 72 hc stal Hygiene. of other than "natul event, the Medical	Be	17. Father's Name (First, Middle, I						me (First, Middle,		Sumame)	
<u>S</u>		우	Sanford Grif			10h Madia	- Address (Careet		de Bass		Tour State 7in	Code) 19351
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationsh Betty Jane G		n - Wif							
	s 1 an if Heal item 2 other		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of		Date		cation - City or Te	
Ē	90 = 5		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc		n State		natory or other plac ville C	1	4/17/08	Kem	blesvi	lle, PA
Baltimore,	artin orts Inju		21. Signature of unional Service	- 100	200442		Name and Addres					
m	Depa Impo eny I		tent Y	2h-h		2	00 Rose	Hill	Road, W	est	Grove,	PA 19390
Ž,			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause or	caused the death each line.	n. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a /	Theroso	lesol	io Mean	1-DI5	ease			unknown.
	/Medical Examiner		resulting in death)	Due to	o (or as a consequ	uence of):						
и		e_	Sequentially list conditions, if any leading to immediate	Due to	o (or as a consequ	uence of):						
	uted d ansit	Examin	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
o O	be executed ician and burial-transit		resulting in death) Last	Due to	o (or as a consequ	uence of):						
8760,	ys e	licai		d								
× 68	The law requires that the deatr certifica sie has been signed by the attending th page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c If yes o	utcome of pregna	nev					04 0-1	_
P.O. Box	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fetal	Ideath 3□	Ectopic pregnancy Other (specify)			2	3d. Date of deliv! Month	ery Day Year
o.	the di y the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk		Jun. J	cirial (speelif)					
	uires thet the de signed by the a Id be detached f	by Pi	Part II. Other significant condition	ns contributing to	death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco u	se contribute to t	he cause of death?
ğ	w require been sig should b	ed t							1 🗆	Yes 2	□No 3□Pro	bably 4 Honknown
Records,	taw re as be 2 sho	Completed							24a. Was		prior to co	opsy findings available ompletion of cause of
	The sete h page	Com								ormed?	death? 1 ☐ Yes	
Vital	lcian: sertific ector.	Be	25. Was case referred to medical examiner?	Hospital:			. 20 pos Oth		eath (Check only			
0	ding Physician: The tav h. After this certificete has funeral director, page 2	- T	1 Yes 2 No 27. Manner of Death	11	Inpatient 2 e of Injury	ER/Outpatien 28b. Time of	I 3LI DOA	4 Nursing	Home 5 Resi			(y)
on	ding th. After	tion	1 Natural 5 Pending	(Mc	onth, Day Year)	Injury	Wor	k? Yes 2 □ No			, , , , , , , , , , , , , , , , , , , ,	
Division of	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could r	ot be 28e. Pla	ce of Injury - At ho		eet, factory, office		28f. Location (City or To			al Route Number.
ā	tal or	Certification:	4 ETTOMICIO	ou.	lding, etc. (Specify	" ————————————————————————————————————			Only of 10	wii, Olale,	<u> </u>	
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical	29a. Certifier 1 Certifyin (Check only one)	xaminer: On the	basis of examina	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as s place, and due t	itated. o the cause(s)
	To the within 2 To the complet	-	Ω		anner stated.		29c. Licens	e number		29d. Date	e signed (Month,	
	F 3 ⊨ ŏ		1 Jack	0.15	MY		200	23322	-	4	1:14.08	ر ح
	10		30. Name and address of person S. Shock. 31. Date filed (Month, Day, Year)	who completed ca	use of death (Item	1 23a) (Type,	Print) Surla	3B, E	Ck Ton M	1)21	1921	,
	Sta Registr	ite	31. Date filed (Month, Day, Year)	2008 32	Aegistrar's Signa	8 4	ore				•	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2005 /Medical 4c. County of Death acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 2/7/1913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Days Hours 1□M 2□F Yrs. 95 Minnesota 577-30-4487 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1702 Bentley Rd. 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 þ Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Statistician Veteran's Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Olafson Sarah Jonasdottir ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arlene S. Lawson/ Daughter 9218 Goldenrod Ln., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4/17/08 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Value 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final teriosc **Physician** disease or condition resulting in death) /Medical ue to (a as a consequence of): Examiner per Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician al s the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🐼 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has b 25. Was case referred to medical examiner? 1 1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 은 1 Inpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturai 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

APR 15

32. Reastrar's Signature

Examiner

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated

UNPENDED

past 12 months?

IF FEMALE:

events resulting in death) Last

23b. Was decedent pregnant in the

1 Yes 2 No 9 Unknown

Part II. Other significant conditions

25. Was case referred to medical

examiner?

1 🗸 Yes

2 🗸 Accident

29a. Certifier 1

27. Manner of Death

Natural

Suicide

Homicide

29b. Signature and title of certifier

and - transit attending physician or use as the burial signed by the at the detached fo certificate has After this c funeral dire

Physician/Medical Completed Be Certification:

The law requires that the death certificate be executed after ceath.

Director: A in by the fi dinb

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: an 24 ho.
• Funeral within 2.

30. Name and address of person who completed cause of death (Item 23a) 10 Margarita Korell MD. 31. Date filed (Month) **State** Registra

Medical

Assistant Medical Examiner

Due to (or as a consequence of):

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy

Pregnant at time of death

AMENDED

9

Hospital:

Pending

Investigation

Could not be

determined

Live birth

Unknown

28a. Date of Injury (Month, Day,Year) Apr 5, 2008

and manner stated

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Fetal death

Other (Specify)

5

Inpatient 2 V ER/Outpatient 3

(Specify) Major Road / Highway

contributing to death but not resulting in the underlying cause given in Part I.

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc

0653 hrs

April 6, 2008

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Yes 2 ✔ No 3 Probably 4 Unknown

death?

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

✓ Yes

Day

24b. Were autopsy findings available

prior to completion of cause of

Month

24a. Was an

✓ Yes 2

or Town, State) Southbound Rt. 65,

Nursing Home 5

autopsy performed?

No

Residence 6

Driver auto fixed object collision

28d. Describe how injury occurred

Year

No

3 Ectopic pregnancy

26.Place of Death (Check only one)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 V No

DHMH 17 Rev 1/2001

Registrar

16

2008

			For State Registrar	State of M	arylan	•		nt of H		ind Me		giene Reg. No.	200	8	1	63
	Physici /Medi		1. Decedent's Name (First, Middle, Las EDWAPD T	<u>.</u>	ER	TON					2. Date of De	Day	ę ž	368	3. Time of 0 7	Death M
Ď.	Examir	er	4a. Facility Name (If not institution, give 2513 Howard Gro	ove Rd.			D	avids	Location o	le			County of Anne	Aru		
ŀ	Funeral Director		5. Social Security Number 6. S 219-90-6319 Usual Residence of Decedent	7. A	ge (In yrs. 44	Yrs.	Month	er 1 Year s Days	II Under 2 Hours	Min.	B. Date of Bir (Month, Da July 7	ıy, Year)	63 V	Nash	ace (State o ry) ingtoi	n D.C
	ne Maryland 8a-f show pilitied at	Director	10a. Slate 10b. County MD Anne Ar	rundel		y, Town or L vidson	vill)d. Inside C	
	ath with the 23a or 2	rat Dire	10e. Street and Number 2513 Howard Grove	Rđ.			10f. 2	2103!	5				usa USA			
030	in 72 hours after death with the Maryland "nature!, or iteme 23a or 28a-f show ladical Examinar must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 💆 Divorced	12. Was Decedent Armed Forces' 1 XYes 2 ☐ If Yes, Give Year or Dates:	No No		If Yes, sp	edent of Hi ecify Cuba 2 X No	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto Ri	ify Yes or No ican, etc.))-	Specify:	America White, e	etc.	
9500-61212	l within iene.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or	5+)	(Give	DO NOT	use retired	lurina most	of working	7		nd of Busin		ustry Local	26
yland	should be filed ind Mental Hygi imarked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Robert R. Howei						Ann i	Marie	First, Middle Griff	fin				
, Mar	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Theresa A. Keane		- I	251	3 Ho	ward (Grove	Rd.		dsonv	ille	, MD	2103	5
ilmore,	m O		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		C	lace of Disp emetery, cre inity	matory o	other place		Da /21/2			cation - Ci lorf ,		wn, State	
Dail	permit. Pege Department Important: if eny injury o		21. Signature of Funeral Service Licen	Ider					s of Facility ain H	E	Beall H					
	Physician /Medical Examiner	200	23a. Part1. Inter the disease, or come shock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or as	lor	ion	a L	ode of dying	g, such as o	cardiac or	fastar	rrest,			Approximat Interval Bet Onset and 7M	ween
8/00,	ite be executed lysicien and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.												
O. BOX 6	the death certifics y the ettending ph iched for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	⊒Ectopic ⊒ Other (pregnancy specify)				2	23d. Date of Month		•	Year
ras, F.	law requires that the de es been signed by the e 2 should be detached f	b	Part II. Other significant conditions o	ontributing to death t	oul not res	ulting in the u	underlying	cause give	en in Part I.		23e. Did t		0	ute lo the	e cause of o	death? Unknown
II Kecords,	The ete h	Completed									24a. Was auto perio		pric	or to com ath?	sy lindings apletion of a	available ause of
VITAI	ilng Physicien: n. After this certific funeral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	100		Check only					
5	P ille	. To	1 ☐ Yes 2 €No 27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatie 28b. Time of		JOA	4 🔲 INUI	rsing Home	e 5 Resi)	
UNISION		Certification:	1 Accident 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Da	i <i>y Year)</i> jury - At ho	Injury ome, farm, st	М		(? Yes 2⊡t	No	8f. Location (Street and	d Number		Route Num	ber,
Ś	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	ai Cert	29a. Certifier	building, e	of my kno	wiedge, dea	th occurre	d at the tim	e, date and	d place, an	City or To	cause(s)	and mann	er as sta	ited.	
	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medicai	(Check only 2 Medical Examone) 29b. Signature and title of gertifier	iner: On the basis of and manner st	of examina lated	tion and/or in		on, in my op 9c. License		th occurred	d at the time,		place, and			5)
2	3/1		30. Name and address of person with	completed dayse of	death (Item	23a) (Type	Print)	0~	214	138	HVA	4	M	1 / /	5/2	008
	Sta		31. Date filed (Month, Day, Year) APR 1 7 2008	A E W	rar's Signa	ture	447	NET	EVS!	t mo	MAY	4 .0VV	11401	יאו ני-		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Dea 01:20 1. Decedent's Name (First, Middle, Last) April 14 2008 **Physician** C. B. Holmes Lucy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Cheverly Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** April 23 Days Hours Baltimore MD. 220-18-6407 1 □ M 2 □XF 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Prince Georges Springdale MD. 1 ☐ Yes 2 🛣 No Director 10g. Citizen of What Country? 10f. Zip Code 20774 10e Street and Number 3105 La. Dova Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Black 1□Yes 🛣 No Baltimore, Maryland 21215-0036 Specify Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Worker Government 17. Father's Name (First, Middle, Last)
Moses Prophet 18. Mother's Name (First, Middle, Maiden Surname) Clark Bessie Hatcett ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 9502 Stoney Ridge Rd. Springdale 20774 Patricia A. Browne (Daughter) 20c. Location - City or Town, State Chelten ham MD. 20a. Method of Disposition

14 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4-21-08 MD. Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral 908 Kennedy St. N.W. Wash, 21. Signature of Funeral Service Licensee 20011 Luna rances 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** estonan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 10 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours after Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

31. Date filed (Month, Day, Year APR 1 7 2008 **APR 17**

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	larylan		artment rtificate			nd Me		giene Reg. No.	2008	inched terminglight	165
Ī	Physic		Decedent's Name (First, Middle, Patr	_{Last)} icia A. Ha	.11						2. Date of Dea Month April		2008 Year	3. Time (of Death
	/Medi Examir		4a. Facility Name (If not institution, 3941 Paddrick	_	7)			Town, or	Location of		ath 4c. County of Death Harford				
	Funeral Director		218-46-4881	6. Sex 7. A 1 □ M 2√√ F	ge (In yrs. 52	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da) 2/4/195	h y, Year) 56	Cou	place (State intry) Land	or Foreign
0036	e Maryland la-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Harfo	rd	10c. City, Town or Location Darlington									10d. Inside (City Limits
	th with th	al Director	10e. Street and Number 3941 Paddrick	Road			10f. Zip 210				10g. Citizen of What Country? USA				
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ha Madical Examinar must be notified at	by Funeral	11, Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces	1 Yes 2 No			Was Decedent of Hispanic Origin? (Spec if Yes, specify Cuban, Mexican, Puerto Ri			ify Yes or No- lican, etc.)		14. Race - Ameri Black, White Specify: W		
9500-61212	d within 72 ho giene. or than "natur the Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		5+)	(Give life. i	dent's Usua kind of wor DO NOT us e (LPI	k done d e retired)	urina mast i	of working	g		nd of Business/Ir		
Maryland 21	should be filed and Mental Hygie in marked other tumatic event, it	To Be C	17. Father's Name (First, Middle, L Darrell James	Ashley					Eli	zabet	(First, Middle, th Ann	Pars	sons		
	0.00		19a. fnformant's Name/Refationsh Lawrence E. Hall			3941	Paddı	rick	Road,		Route Number		Town, State, Zi, D 2103	_	
saitimore,	of H		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 4 ☐Donation 5 ☐Other (Sp		7	lace of Dispo emetery, cren Zion			1	Da 25/2/			cation - City or T . Air, M		nd
Rail	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	cense	On	1 22	. Name and	d Addres	s of Facility		lta, P		1,800,000		
8/00,	Physician physician and physician and physician and physician and the physician in the physician	dical Examiner	23a. Part1. For the disease, or of shock, or heart failure. List of firmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	AS s a consequence s a consequence	THM; uence of):		e of dying	j, such as c	ardiac or	respiratory ar	rest,		Approxima	etween
O. Box 6	law requires that the death certificate as been signed by the attending physic should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 □ Yes 2 BNo 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)									2	3d. Date of deliv Month	ery Day	Year
7	quires that in signed b uld be deta		Part fl. Other significant condition		but not resu	ulting in the ur	nderlying ca	use give	n in Part I.			bacco us	se contribute to t	the cause of	
al Records,	n: The law re icate has bee r. page 2 sho	Completed by		STENOS	STENOSIS						autop	24a. Was an autopsy findings average performed? 1 Yes 2 To 1 Yes 2 No			available cause of
ı vıtalı	ysicial lis certi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ fnpati	ient 2 🗆 I	ER/Outpatien	t 3 DO/	1 04	r		Check only or e 50XResid		☐Other (Speci	fv)	
vision or	To the Hospital or Attending Physician: The law within 24 buous elled add. Within 24 buous elled add. Completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1. Tratural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	t be	ay Year)	28b. Time of Injury	М			28	d. Describe h			··	
2	pital or At ours efter o eral Directilled in by		4 ☐ Homicide determin	building, e	tc. (Specify	")					City or Tow	n, State)	i Number or Run		nber,
	he Hos n 24 hc he Fun pletely	edical	(Check only 2 Medical E	Physician: To the best carniner. On the basis of and manner st	of examinat	wiedge, death ion and/or inv	occurred a restigation,	it the time in my op	e, date and Inion, death	piace, an occurred	d due to the o	ause(s)	and manner as s place, and due t	stated. o the cause(s)
	To t Withi Com	×	29b. Signature and title of certifier Audrew	Vowalis	w	e. "	29c.	License Do	number 80 9	76	4,	29d. Date	signed (Month,	Day, Year)	
			30. Name and address of person w	ho completed cause of	death (Item	23a) (Type,	Print)								
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Regist			81				· · · · · · · · · · · · · · · · · · ·				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23a per dr., 8879.05/12/08dhb
Reg. No.
Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Frances C. Isaksen 10:32 April 13 2008 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Ye DeC 11, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ^{Year)} 1930 **Funeral** Days Washington D.C. 1 ☐ M 2 ☐ XF Yrs 77 Director 577-36-8320 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Crownsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21032 USA 2008 Martins Grant Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 → Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) U.S. Government Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elwood Valentine Erma Ford ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 Martins Grant Ct. Crownsville, MD 21032-1932 19a. Informant's Name/Relationship (Type. Print) Joseph B. Isaksen / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD Veteran's Cemetery 4/21/2008 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of uperal Service Licenses 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Seizure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregrant 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ should be 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 ☐ Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 \ N 1 Inpatient 2 1 TYes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 5 ☐ Pending investigation 1 □ Natural M 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed) (Month, Day, Year) 29b. Signature an

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonth. Day.

7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DR16 2008 ESTHER JACKSON 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death DOCTORS COMMUNITY HOSPITAL PRINCE GEORGES LANHAM If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 □ M 2 X F Yrs. 05/05/1916 NORTH CAROLINA 578-36-1124 91 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State XXYes 2 □ No PRINCE GEORGES CAPITOL HEIGHTS MD10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20743 1208 DUNBAR OAKS DRIVE 14 Bace - American Indian. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify BLACK 3√DWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 YEAR (1-4or 5+) SUPERVISOR PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARGIE DEAL JOHN COLEMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1208 DUNBAR OAKS DR. CAPITOL HEIGHTS, MD 20743 TERRECIA GREEN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State MARYLAND NATIONAL 04/18/2008 | LAUREL, MD 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Juneral Service Licensee 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final POLYMICROBIAL SEPSIS disease or condition resulting in death) Due to (or as a consequence of): INFECTED DEUBITUS ULCERS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) HYPERTENSION Due to (or as a consequence of) ASPIRATION PNEUMONIA

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" -- " any Injury or other traumatic excess."

death with the Maryland

and

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

nours after death.

neral Director: After this filled in by the funeral di

vsician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23d. Date of delivery Month Day	Year						
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacco u	se contribute to the cause of	death?			
DIABETES MELLI	TUS			1 ☐ Yes 2 ∑	No 3 Probably 4 □]Unknowr			
MULTIFACTORIAL				24a. Was an autopsy performed? 1∐ Yes 2 ☑ No	24b. Were autopsy findings prior to completion of death? 1 □ Yes 2 ☒ No	available			
25. Was case referred to medical examiner?	Eo. I lado di Boatti (oriota di								
1 ☐ Yes 2 🔀 No	Hospital: 1 X Inpatient 2 [☐ER/Outpatient 3☐ D	OA Other: 4 Nursing	Home 5 ☐ Residence 6	6 ☐Other (Specify)				
27. Manner of Death 1 → Natural 5 → Pending 2 → Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred				
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and City or Town, State	d Number or Rural Route Nui)	mber,					
	Physician: To the best of my kn aminer: On the basis of examin					(s)			

29c. License number

021200

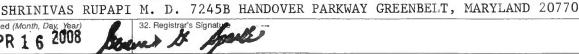
29d. Date signed (Month, Day, Year)

ANRIL12.2008

State

31. Date filed (Month, Day, 2008 APR 16

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Registrar

APR 1 6

32. Registrar's Sign

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:39 ^{ам} 4/14/2008 Sidney M. Kearns /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 1978 Marconi Circle Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/27/1919 Birthplace (State or Foreign Country). 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Mir 1⊠M 2□ F Cheverly, MD Yrs 89 **Director** 220-05-9395 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2 X No Funeral Director Anne Arundel Annapolis MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21401 U.S.A. 1978 Marconi Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 152 Yes 2 □ No If Yes, Give WW II Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bartender Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Lou Bertha Trammel James B. Kearns ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1978 Marconi Circle, Annapolis, MD 21401 Charlotte K. Kearns-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4/16/2008 Arlington, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 4739 Baltimore Ave. Zanning Gasch's Funeral Home, P.A. Hyattsville, MD 2078 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the deeth. Do med enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respansor **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 60 Sequentially list conditions, if any leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 9 II Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1 □Yes 2 4NO 1 🗌 Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Certification: To of this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Division 5 Pending investigation 1 Natural 1 🗌 Yes 2 No death. after death 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 14, 2008 136761 21/3M 120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hue fore 31. Date filed (Month, Day, Year)
APR 1 7 2008 32. Registrar's Sign State Registrar

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Physi	cian		gistrar Decedent's Name (First, Midd	le,Last)						2. Dat	e of Death	ν,	Year	3. Time of Death 0313 hrs	
	nine	r	Ausencio Sant	os Lug	0						il 13, 2008	40 Cour	nty of Death		
		4.	a. Facility Name (if not instituti	on, give stree	et and number)	1	lb. City, Town, Riverdale	or Location of	Death			e George		
		Ļ	5624 67th Avenue	10.0	7.00	ge (In yrs. las	hirthday)	If Under 1 Y	ear I If Unde	24Hrs. 8. D	ate of Birth(M	M/DD/Y	(YY) 9. Birt	hplace (State or	
Funer Direct		5	Social Security Number	6. Sex		23		Months D	ays Hours	Min.	3-29-19		Foreig	ⁿ ^{untry)} M e xico	
Direct		Ļ	none	1X M	2F	23	Yrs			1 10.	-29-15	705_			
any		_	sual Residence of Decedent 0a. State 10b. County	,		10c. City, T	own or Locat	ion						10d. Inside City Limits	
*	<u>.</u>		MD Princ	e Geo	rge's	Riv	verda1	e						1 X Yes 2 No	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland beaparment of Health and Mental Hygiene. Department of Health and Mental Hygiene.	Director	3 1	0e. Street and Number	0 0 0 0 0				10f. Zip Code	9		10g.	Citizen o	f What Coul	ntry?	
the Ma	illed	5	5715 64th Ave	enue				20737			Mexi				
with t	00 0		1. Marital Status	12.	Was Deceder Armed Forces		. 13. Wa	as Decedent of es, specify Cu	Hispanic Orig	in? (Specify ' Puerto Rican	Yes or No- , etc.)		Race - Amer Vhite, etc.	ican Indian, Black,	
death r iten		runera		Married 1	Yes	2X No						Sner	ify: Whi	+0	
after all.	iner			ivorced If Ye	lates:	Interd		Yes 2					of Business/		
hours	Exam		15. Decedent's Education (Sp		College (1-4 o	,	during n	nost of working	life. DO NOT	use retired)					
36 in 72	lical :	D E	Elementary/Secondary (0-12	,	Concect	, ,	Lab	orer					truct	ion	
5-0036 Ited within 7 Hygiene.	C NF	Completed	6th 17. Father's Name (First, Midd	e, Last)					18.Mother	's Name (Firs	t, Middle, Mai	den Surr	ame)		
215 e file tal Hy	1 2	Re	Isabel Santos		nozā				Pau1	a Lugo	Lopez		- 0	7:- 0-4-)	
2121 ould be fill Mental F	ic ev	2	19a. Informant's Name/Relatio	nship (Type,	Print) (br	other)		ng Address (S							
MD rd 2 shoulth and 27 is	umat	-1	Andres Jaime	Santos	Lugo	1000				• #421 Dat	Rivero	1ale	tion - City o	r Town, State	
Fear The First T	r tr		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place)												
Pages Pent of	f		4 Donation 5 Other	Specify:		Fa	mily (Cemeter	У	04-24				ebla, Mexico	
Baltimore, permit. Pages I an Department of Hear	jury		21. Signature of Funeral Servi	ce Licensee	non 1	121								ome, Inc.	
<u>ന ഉപ്</u>	. <u>s</u> ′	4	WAKOA L 23a. Part I. Enter the disease,	19040	ions that saus	od the death	Do not enter	447 14t	h St.	N.W. W	ashing oiratory arrest	t, shock,	or heart	Approximate interv	
'ysic' i			failure. List only one cau	se on each i	ine.	CG WIO GOOW								Between Onset an Death	
_xami	_	1	Immediate Cause (Final disea or condition resulting in death		ad Injuries to (or as a co	nsequence of	·):							1	
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pate	ansit	ωļ	events resulting in death) La	d.											
execu	al - tr	[S]	UNPENDED	A	MENDED	-									
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Box 68760 e death certificate b	e as th	jan/	23b. Was decedent pregnant i past 12 months?	n the	1 Live birth	n it at time of de		Fetal death Other (Spec <i>ify</i>		oic pregnancy		") III I	50,	
OX eath o	for us	Sici	1 Yes 2 No 9	Unknown	9 Unknow		2	Other (Specify							
	sched	된	Part II. Other significant con	nditions co	ontributing to d	eath but not r	esulting in th	e underlying ca	use given in	Part I.				to the cause of death?	
P.O.	e deta	ò									1 Yes	2 V N		robably 4 Unknow	
ds,	ould	Completed									24a. Was a autops	y i	prior t	autopsy findings availa to completion of cause	
COr Law I	e 2 sh	du									perform		death 1 ✓		
. ₽	r, pag		25. Was case referred to me	dical				26		th (Check only					
/ital sician	Imis cent	Be	examiner?		spital: 1 Inp	patient 2	ER/Outpati	ent 3 DO	Other ₄				e 6 🗸 Ot	her: Scene	
of V	Atter in funeral o	: To	27. Manner of Death		28a. Date of	Injury Day Year)	28b. Time	* '	. Injury at W	s_	d. Describe h ibject sust	ow injury ained t	occurred Slunt hea	d injuries	
on o		tion		Pending	Apr 13, 20		0300 hrs		Yes 2	No					
Division of Vital Records, P.O. Box 68760, To the Hospital or Physician: The law requires that the death certificate be executed within 24 hours after death.	Pending Investigation 2 Accident 3 Suicide 4 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 5624 67th Avenue, Hyattsville, Md 28f. Location (Street and Number or R or Town, State) 5624 67th Av														
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Hosp 24 hou	etely f		(Oncon entry	g Physician	: To the best	of my knowled	dge, death od	courred at the ti	me, date and pinion, death	place, and du occurred at th	e to the cause ne time, date a	e(s) and and place	manner as s e, and due to	stated. o the cause(s)	
≝.⊑	To the Fur completely	Medical		a	on the basis of and manner sta	examination at	and/or mivest		License numb			29d. Da	ate signed ((Month, Day, Year)	
2 =	_ ~ .			rei fior				250.	LIVETING HUITE				- '		
P. P. M.	- 8	Ž	29b. Signature and title of co	a/					OCME			April	13, 2008		
O Cal	7	Ž	29b. Signature and title of ce	thall.	mo				O.C.M.E.			April	13, 2008		

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year)
Registrar APR 1 6 2008

ORIGINAL

32. Registrar's Signature

OCME

The law requires that the death certificate be executed physician and is the burial-trans attending p page 2 s funeral director. the

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O 2008 Month APRIL 6:15A PENNY LOWE 10 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 30 1925 5. Social Security Number Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days Hours Min. NORTH CAROLINA Director 237-36-2011 82 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Directo MD PRINCE GEORGE'S LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9001 CHERRY LANE 20708 USA Funeral "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2X No BLACK Specify þ 3 □ Vidowed 4 □ Divorced Hygiene. other than "natur ent, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6TH LINEN SERVICE WORKER PRIVATE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM B. SCOTT JOSEPHINE BANKS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANICE WHEELER/GREAT NIECE 6102 86th AVENUE NEW CARROLLTON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State COOL SPRING CHURCH 4 Donation 5 Other (Specify) 4/18/2008 GASTON, NORTH CAROLINA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Fart1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INFARCTION OF SMALL & LARGE BOWEL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SECONDARY TO ARTERIAL OCCLUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ACUTE MYOCARDIALINFRACTION resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No 24a. Was an 1⊠ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA မ 1 ☐ Yes 2 ☑ No 1 Hnpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca (Check only one) and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D67108 April 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SADIG SYED M.D. 14333 LAUREL BOWIE ROAD # 208 LAUREL, MARYLAND 20708 31. Date filed (Month, Day, Year) 2008 APR 16 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State State Registrar	ate of Marylan		artment of F rtificate of			giene Reg. No. 2	008	1473	
r	Dhusisi	美	1. Decedent's Name (First, Middle, Last)				Dour	2. Date of De	ath		3. Time of Death	
	Physici /Medic	cal		ka: Bobby	Lee Le		v Location of Death	April		2008ar	5:20 AM	
	Examin	er	4a. Facility Name (If not institution, give street 6128 Dry Log Street	and number)		Seat Ple	r Location of Death easant				eorge's	
£.	Funeral Director		5. Social Security Number 578–48–9075 6. Sex 1 [X]M 2	7. Age (In yrs. 69	la <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl	h 38 ^{ar)}	9. Birth Wash	nplace (State or Foreign unity) nington, DC	
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits	
	e Mary la-f sh tifled a	ctor	MD Prince Geor	ge's Se	at Plea	asant				1 X Yes 2 □ No		
	with th	Director	10e. Street and Number 6128 Dry Log Street			10f. Zip Code 20743				of What Col		
	death	Funeral	11 Manital Status 12. W	as Decedent Ever in U	I.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		Race - Amer Black, White	rican Indian,	
5-0036	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ If Ye	TYes 2 No 19 Yes, Give 19 ear or Dates: 19	55-	1 □ Yes 2 No	Specify:	o nican, etc.)			Lack	
בה	n 72 h "natu edical	Completed	15. Decedent's Education (Specify only highest grade com		16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	king	16b. Kind	of Business/I	Industry	
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and	Mental Hygie arked other atic event, the	To Be C	17. Father's Name (First, Middle, Last) Curtis Lewis				18. Mother's Nam		Maiden Su	rname)		
lary	2 should be and Menta Is marked raumatic ev	_	19a. Informant's Name/Relationship (Type. Pr	1			and Number or Ru					
e, s	1 and Health em 27		Jacqueline Pemberton 20a. Method of Disposition			Dry Log sition (Name of matory or other pla	Street S	Date		tion - City or		
E E	Pages ient of nt: If it iry or o		1 Burial 2 □Cremation 3 □ Remov 4 □Donation 5 □ Other (Specify)	ai iroiii State		matory or other pla coln Ceme	1	-2008		wood,		
baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ee once.		21. Signature of Funeral Service Licensee		22	2. Name and Addre	ess of Facility Followship		coln F	uneral	Home	
B			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cal	ns that caused the dear	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	
ì	Physician		Immediate Cause (Final	UNG CARCIN	OMA						Onset and Death	
	/Medical Examiner			Due to (or as a consec	quence of):							
ľ	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consec	quence of):							
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	ertifica ling ph	Med	IF FEMALE:									
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ν., Γ.	s that the ned by th e detache	by Ph	Part II. Other significant conditions contribut	ing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to	the cause of death?	
Spuc	requires een sign rould be		Diabetes Mellitus, H	ypertensio	n			1 🗆	Yes 2X	No 3□Pr	obably 4 Unknown	
vitai несогаs,	e la has	Completed						24a. Was auto perfo 1□ Yes		24b. Were au prior to death? 1 □ Yes	utopsy findings available completion of cause of 2 No	
VII	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al·		Oth	26. Place of Dea					
0	Phys this al dil	. To	27. Mapner of Death 28	a. Date of Injury	28b. Time o	IL SUDOA	4 LI Nursing H	ome 5 Resi 28d. Describe			cify)	
NOIS	Attending Fr death. ector: After by the funer	atio	1 ♣ Natural 5 Pending investigation	(Month, Day Year)	Injury		rk?]Yes 2 ☐ No					
DIVISION	after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	e. Place of injury - At h building, etc. (Speci	iome, farm, str ify)	eet, factory, office		28f. Location (City or To		√umber or Ru	ural Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: 0									
	To the within To the	Me	29b. Signature and Me of certifier	1		29c. Licens					h, Day, Year)	
	(2)		· Vymcyr	M		D 263	82		4/16	/2008		
R	- 3		30. Name and address of person who comple Marc R. Shepard, M		m 23a) (Type, K-St N		ngton, DO	3 Sto 31	0 20	006		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ture	wasiil	ing cone De	DIE JI	.0 20	000		
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DHMH 17 Rev 1/2001

		_ For	Plea	ase Type or Pr State of N					Ensure A ealth and I		/giene			a mar h
		1 - State Registrar				Ce	rtificate	of L	Death		Reg. No	2008	3	174
Physic	ian	1. Decedent's Nam	e (First, Middl	lle, Last)						2. Date of D Month	eath Da	y Year	3. Time of	
/Med				ys Wallace Lo						April	10			•0 рм
Exami	iner			on, give street and numbe	r)		4b. City, To		Location of Death		40.	. County of Dea		
	*	5. Social Security N		f Wheaton 6. Sex 7. A	Age (In vrs.	last birthday) If Under 1		Silver Spri				tgomery rthplace (State o	r Foreign
Funeral Director		056-03-01		1 M 2 X F	94	Vre		Days	Hours Min.	January	ay, Year)		Country)	York
τ		Usual Residence o			74									
arylar show dat	-	10a. State	10b. County	/	10c. Ci	ty, Town or L	ocation.					10d. Inside Ci 1 ☐ Yes		
he Ma 8a-f	Director	Maryland		tgomery			100 70 0		lver Spring	3	40 00		2 110	
with t	ä	10e. Street and Nu					10f. Zip Co	ode	20906		10g. Cii	tizen of What C	S.A.	
ILE 13-UU30 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	11. Marital Status	iewitt Av	venue, #44 12. Was Deceder	nt Ever in U	I.S. 13.	. Was Deceder	nt of Hi	ispanic Origin? (S in, Mexican, Puert	pecify Yes or N	0-	14. Race - Am		
or Iten	F	1 Never Mari	ried 2∐ Mar	Armed Forces mied 1 ☐ Yes 2 2	5?					o Rićan, etc.)		Black, Wh	ite, etc.	
Dours a	ğ	3 🗷 Widowed	4 ☐ Divorced	d If Yes, Give Year or Dates	:		1 □ Yes 20 2	& NO	Specify:			Specify:	White	
72 hc	Completed	(Spe	15. Deceder cify only highe	nt's Education est grade completed)		16a. Dece	edent's Usual C e kind of work	Occupa done o	ation during most of wor l)	king	16b. K	ind of Busines	s/Industry	
vithin vithin than than the Me	I dr	Elementary/Seco	ondary (0-12)	College (1-4o	r 5+)	lite.		retired, mema				0	n Home	
filed v Hygie int, th	ပ္သ	17. Father's Name	(First, Middle,	. Last)			но	шеша	18. Mother's Nan	ne (First, Middle	e, Maider		1 поше	
d be fill ental H ked oth	To Be			mfield Wallace					E1:	sie Burgo	vne	,		
pattilliote, intal ylallo ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Ĕ	19a. Informant's N				19b. Mail	ling Address (S	Street a	and Number or Ru			or Town, State,	Zip Code)	
alth a 27 is		Barbara	Manning	g - Daughter		3240	Hewitt.	Aver	nue, #44, S	Silver Sp	ring,	Maryland	1 20906	
of He of He rothe		20a. Method of Dis		0.000	20b. i	Place of Disp	oosition (Name ematory or othe	of er plac	e)	Date	20c. L	ocation - City o	or Town, State	
antimor rmit. Pages partment of portant: If it y Injury or o		1 ☐ Bunal 2 4 ☐ Donation		3 ☐ Removal from Stat Specify)	e		oln Crema			6/2008	Bre	ntwood,	Maryland	
eparti eparti porti ny Inj		21. Signature of F	uneral Service	e Licensee			22. Name and A	nald	li Funeral	Home. In	C.			
	1	1 Our	mak	Ment	u-		11800 Ne	w Ha	ampshire Av	renue, Si	lver :	Spring, M		
Physician /Medical Examiner	1	Imme Tause disease or condition resulting in death)	art failure. Lis (Final on	a. Failure Due to (or a	line. to The same of the same	rive quence of):	nter the mode o	or dylni	g, such as cardiac	tor respiratory	arrest,		Approximat Interval Bet Onset and I	ween Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
w requires that the death certification is signed by the attending I should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)										Year		
o, r	by P	Part II. Other signi	ificant conditi	cions contributing to death	but not res	sulting in the	underlying cau	ise give	en in Part I.	23e. Did	tobacco	use contribute	to the cause of c	death?
require een sig	ed	Coronary	Artery	Disease						1	Yes 2	!□ No 3□!	Probably 4 🛣	Jnknown
ding Physician: The law range by Affer this certificate has be funeral director, page 2 sh	Completed	Diabetes	Mellitu	us Type 2						per	s an opsy formed? 2 🗷 No	prior to death?		available ause of
v II.e iclan certifi ector,	Be	25. Was case refe examiner?		Hospital:				Othe	26. Place of Dea					
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ding h. After funel	ion	1 🗷 Natural	5 Pendir	/Adamah /	Day Year)	Injury	M 280	c. Injun Work	yan k? Yes 2∐No	zou. Describe	r now inju	ily occurred		
To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Certification:	2 Accident 3 Sulcide 4 Homicide	6 Could determ	I not be 28e. Place of i	njury - At h etc. <i>(Speci</i>	l iome, farm, s ify)	treet, factory, c			28f. Location City or To			Rural Route Num	nber,
To the Hospital within 24 hours a To the Funeral completely filled	Medical (29a. Certifier (Check only one)		ing Physician: To the bear If Examiner: On the basis and manner	of examin		investigation, in	n my o	pinion, death occu					s)
With Tot	Σ	29b. Signature and	d title of certifie	er / n	/	7	29c. L		e number		29d. Da	ate signed (Mo	nth, Day, Year)	
60		1	Lan	R Ses	all	wy		D5	52261		A	pril 10,	2008	
Ψ				n who completed cause of		/				2006				
	toto	Alan R. 31. Date filed (Mor		M.D., 1517 Hugo	strar's Sign	ature		ıg, M	Maryland 20	J906				
Si Regis	tate trar	AP	R 16	2008	2	La	ede							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

1. Decedent's Name (First, Middle, Last) LaBrie Apri **Physician** Donald 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 9+ Johns Hopkins If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 214-66-8204 51 JULY 18, 1956 DELAWARE Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND | QUEEN ANNE'S QUEENSTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 125 GLOUCESTER ROAD 21658 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other than NONE DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f is marked RICHARD THOMAS LABRIE BETTY LOU DABSON 27 is marked traumatic Pages 1 and 2 should nent of Health and Mer ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 125 GLOUCESTER ROAD, QUEENSTOWN, MARYLAND 21658 BETTY LOU LABRIE/MOTHER Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) APRIL 19 STEVENSVILLE CEMETERY 2008 STEVENSVILLE, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Ente shock, or he Immediate Cause (Final disease or condition resulting in death) Sers's

Due to (or as a consequence of): **Physician** weeks /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) o 9∏Unknown 9 Unknown þ σ, signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page nerforn certificate 2 **N**0 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death Check onl one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number

Division within 24 hours at To the Funeral C 2

Registrar

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Year) 31. Date filed (Month, Day, 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

The

MD

Yazmin Morales;

M.D.

Johns Hopkins

32. Registrar's Signature

600 N. Wolfe

Street,

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 04-13-2008 **Physician** A M 9:34 GEORGE S. MOCKABEE /Medical 4c. County of Death 4h. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Min. 14- M 2 □ F Yrs. Wash.,DC 578-10-9699 92 05-19-1915 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylan Ith and Mental Hygiene. ?? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Director Maryland Prince George's Suitland [] 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20746 2514 Fort Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐¥es 2 ☐ No If Yes, Give Year or Dates: 1944 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify Specify: þ 3 ™ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fuel Oil Company Business Owner 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Pearl E. Posey Henry C. Mockabee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 g Department of Health ar Important: If item 27 Is any Injury or other trau once. 8383 Woodline Court Manassas, Virginia 20110 Barbara A. Pearson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 04-19-2008 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tack A. William M01246 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Carebrovalular Unknown /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 □ Yes 2 □ No after death.

Director: / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hours the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely f 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Frank 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave suit 3-32 Silver spring MD 20902 ROINTAN FARAHIFAR 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State 2008

DHMH 17 Rev 1/2001

Registrar

		State of Maryland	•	rtment of H		•	giene Reg. No.	2008	11.17
		Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of De			3. Time of Death
Physici						Month	Day		20:46 M
/Medic		Harold Mattison 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	April	_	008 County of Death	20.40
- Exami		Anne Arundel Medical Center		Annono1	i o		٨٣	ne Arun	do1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	Annapo 1 If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign entry)
Director		249-30-7867 15xM 2□F 89	Yrs.	Wionans Days	riours wiiri.	Feb. 15			rson, S.C.
and		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation				1	0d. Inside City Limits
/aryli	ō		ndover						1. Yes 2 No
r the Maryland r 28a-f show	Director	10e. Street and Number		10f. Zip Code			10a. Citiz	zen of What Cour	ntry?
3a or		2011 Kent Village Dr.		20785			•	ited Sta	•
hours after death with the Maryland hours after death with the Maryland tural", or Items 23a or 28a-f show	Funeral	11. Marital Status 12. Was Decedent Ever in U.S	. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No	- 1	4. Race - Americ	
or Ite		1 Never Married 2 Married 1 See 2 No If Yes, Give			n, Mexican, Puert Specify:	o Hican, etc.)		Black, White,	
ours Iral",	d by	3 Widowed 4 □ Divorced Year or Dates:		□Yes 2☐No	Specity.			Specify: Bla	ack
72 hours aff	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give :	lent's Usual Occupa kind of work done o	luring most of wor	king	16b. Kir	nd of Business/In	dustry
within sne.	Ę.	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired,	•		Se1	f-Employ	ved
filed Hygirther int, the	ပ္သ	8th 17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle.			,
ould be file Mental H arked oth atic even	To Be	Allen Mattison				iana Sc		,	
shoul nd M mar mari	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a				Town, State, Zir	Code)
nd 2 sh alth and 27 is n r traun	Ŋ.	Judy M. Mitchell / Daughter		9 Rupert					^
permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Introductant: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Exeminar is ust because.		20a. Method of Disposition 20b. Pla		sition (Name of natory or other place		Date		cation - City or To	
Page nent c nt: If		Temporal 2 Li Cremation 3 Li Removal nom State		Veterans	i	/2008	Chal	tenham,	Må
permit. Pages Department of mportant: If it any Injury or o		21. Signature of Funeral Service Licer see		Name and Addres	s of Facility	901 H 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2			rid.
e a m e a		+ Rett a Same MOLOST	_	Alexander 5538 Mar	lboro Pap	kė/Forės	tvil	le, Md.	20747
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pe #is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				2	1		
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icate be executed physician and the burial-transit	<u>m</u>	bue to (or as a conseque	stice oi).						
icate phys s the	dical	d							
Physician: The law requires that the death certifer this certificate has been signed by the attending ral director, page 2 should be detached for use as	/Me	IF FEMALE: 23b. Was decadent program 23c. If yes, outcome of pregnan	cv					2d Date of delive	
leath cer attendir I for use	Physician/M	in the past 12 months?	death 3□	Ectopic pregnancy Other <i>(specify)</i>	1		2	3d. Date of delive Month	Day Year
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The la te ha	mo du	Odried Till willow	· O.				rmed?	prior to co death?	impletion of cause of
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To the Hospital or Attending Physician: The law requires that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as									
Hosp 4 hou Fune ely fil	edical	29a. Certifier (Check only (Check only (Check only 2☐ Medical Examiner: On the basis of examination	ledge, death on and/or inv	occurred at the timestigation, in my or	ne, date and place pinion, death occu	e, and due to the irred at the time.	cause(s) date and	and manner as splace, and due to	stated. o the cause(s)
thin 2 the I the I	Med	one) and manner stated.							
5 N Ki	-	29b. Signature and title of certifier	7,	29c. License				e signed (Month,	
2		may 1 peptr He sou	-6	1 04	337/		4	5/08	Facci
\mathcal{D}		30. Name and address of person who completed cause of death (Item 2		Print) Jell NEDICH	Decy.	SEPH HO	CA	5/08 - 2140	1773
Sta	to	31 Date filed (Month Day Year) 32 Begistrads Signar		VEDICT.	Nacy.	TIV THUELD	1 100	×140	/
Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signar							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day April 4, 2008 Medical Examiner 2226 hrs Jose Salvador Merino 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death Johns Hopkins Bayview Medical Center **Baltimore** Baltimore If Under 1 Year I If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** ForeigrE1 Salvador Months Days Hours Director 1X M 2 F none Yrs May 24. 1973 Usual Residence of Deceden any 10a. State 10d. Inside City Limits 10b. County 10c, City, Town or Location 1 X Yes 2 No Baltimore MD Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6820 Red Rose Way Salvador Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes Widowed f Yes. Give Yea 1 X Yes 2 No specify: salvadoran Specify: White 4 Divorced δ, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: If item 27 is marked ... injury or other trans. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2ndLaborer Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Jose Salvador Merino Mariana Molina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oscar Julian Merino (Brother) 3969 Seven Trees Blvd. 98 San Jose CA 95111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Buriat 2 Cremation 3 Removal from State 04-18-08 Family Cemetery Cabanas, El Salvador Donation 5 Other Specify: 22 Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service License 3447 14th ST. N.W. Washington DC 20010. 6 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease ⁻xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical physician a UNPENDED AMENDED The law requires that the death certificate be Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? this certificate h ✔ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

Zo the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other ٩ 1 V Yes 28a. Date of Injury After th 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Apr 4, 2008 Pedestrian struck by auto 1 Natural 2122 hrs Pending Yes 2 V No Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide or Town, State) Interloop of 695 @ Exit 37, Essex, Md. determined (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3 O.C.M.E. April 5, 2008 mis 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 APRI (Manth 2008 ear) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

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State of Maryland	/ Department of He	ealth and Mental	Hygiene

Alvin David Middle		For State	tate o	of Marylar			Health an	d Menta	al Hyg	giene	0.0	
Physicia	F	Registrar 1. Decedent's Name (First, Mid	tle.Last)	Certificate of Death							eg. No.	3. Time of Death
Physician Medical Examin	er	Alvin David	Mid	d1eton						Date of Dear Month April 9, 20	Day Year 08	1945 hrs
	ı	4a. Facility Name (if not instituti 5020 Doppler St.	on, give	street and num	iber)	ľ	b. City, Town, or Capitol Hei		Death		4c. County of D Prince Geo	
Funeral Director		5. Social Security Number 578-70-5862	6. Sex	M 2 F	. Age (In yrs. I		If Under 1 Yea Months Day		Min			Birthplace (State or Foreign Country)
	ŀ	Usual Residence of Decedent	43.23	M 2F		Yrs		<u> </u>		10/28/	1951 W	Mashington, DC
any	t	10a. State 10b. County			10c. City,	Town or Locati	on					10d. Inside City Limits
and show nce	اج	MD Prince	Ge	orges	Cap:	itol He	ights					1 Yes 2XXNo
Maryla 28a-f	Director	10e. Street and Number 5020 Doppler S	tre	et			10f. Zip Code	743		1	0g. Citizen of What	
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ath wi items	Funeral	11. Marital Status 1 Never Married 2	Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.									American Indian, Black, etc.
fter de		3 Widowed 4 X D	vorced	1 Yes If Yes, Give Year	2X No	1	Yes 2 X No	specify:			Specify: B	lack
tours a	<u>ğ</u>	15. Decedent's Education (Sp	ecify onl	y highest grade	completed)	16a. Deceden	t's Usual Occupa ost of working life	tion (Give ki	nd of wo	rk done	16b. Kind of Busin	ess/Industry
36 n 72 h nsn "n lical E	Completed	Elementary/Secondary (0-12 1 2)	College (1-	4 or 5+)		Driver	. DO NOT U	se retire	u)	Private	Industry
5-0036 led within 7 Hygiene. other than the M dica	<u>Ē</u>	17. Father's Name (First, Middle	e. Last)			11461	DIIVEL	18.Mother's	Name (First. Middle. I	Maiden Surname)	Industry
215 be filed ntal Hy rrked o	Be	John Richard M		leton						hel Ar		
D 21 thould I nd Mer is man		19a. Informant's Name/Relation Leon Middleton	ship (Ty	pe, Print)			•				nber, City or Town,	
, MD and 2 sho salth and em 27 is	- 1	20a. Method of Disposition			20h		lason St ition (Name of ce			ct Hei Date	ghts, MD	
Baltimore, oemit. Pages 1 ar Oeparlament of the Important: If the		1 Burial 2 XCrematic	_	Removal from	n State	crematory or oth		.	4/16		Alexandr	
Itim tit. Pa artmen ortant	+	4 Donation 5 Other 5 21. Signature of Funeral Service	pecify:	ee	11101							neral Home, PA
Ba Perm Depid Imp		gudth K	Si	MISS	<u> </u>	650	03 Old B	ranch	Ave	., Tem	ple Hills	, MD 20748
Physician /Medical		234 Part I. Enter the disease, of failure. List only one caus			used the death	. Do not enter th	ne mode of dying,	such as car	rdiac or r	espiratory arr	est, shock, or heart	Between Onset and
Examiner	1	Immediate Cause (Final diseas or condition resulting in death)		Morphine Int		vf).						Death
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		if any, leading to immediate cause. Enter Underlying Cause		Due to (or as a c	consequence o	of):						
=	Examiner	(Disease or injury that initiated events resulting in death) Last		Due to (or as a c	consequence o	of):						
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50, te be executed tysician and burial - transit	edical	UNPENDED		AMENDED								
Box 68760 The death certificate Is the attending physe hed for use as the breather		IF FEMALE: (3b. Was decedent pregnant in past 12 months?	the	23c. If yes, ou	utcome of preg th		tal death 3	Ectopic	pregnan	су	23d. Date of de Month	livery Day Year
Box 6 e death cer the attendi	30	1 Yes 2 No 9 Ui	ıknown		nt at time of de	eath 5 Ot	her (Specify)				393	
that the de detached f	솔.	Part II. Other significant cond		9 Unknov	00-713-713-7-7-7	esulting in the u	inderlying cause	given in Parl	t I.	23e. Did to	obacco use contribu	ite to the cause of death?
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	2	Ū		3			,	,		1Ye	s 2 No 3	Probably 4 🗸 Unknown
Records, The law requir ficate has been s	Completed									24a. Was		re autopsy findings available or to completion of cause of
eco ne law te has ge 2 si	틹									autor perfo	rmed? dea	ath? Yes 2 No
an: Ti	မ်္ဂ မြ	25. Was case referred to medic	al				26.Place	of Death (0	Check or		2 10 1	7,763 2 110
of Vital ng Physician: Wher this certi	인	examiner? 1 ✓ Yes 2 No	H	ospital: 1 In	patient 2	ER/Outpatient	3 DOA	Other ₄	Nursing	Home 5	Residence 6	Other: Scene
n of ording P. h. After e funera	- - -	27. Manner of Death 1 Natural 5 Per	ding	28a. Date of	f Injury Day,Year)	28b. Time of It	,	ry at Work? Yes 2 ✓ I	- 10	8d. Describe Inknown	how injury occurred	
Division Sopital or Attendii hours after death. ineral Director: //	ertification:	2 Accident Inv	estigatio	280 Dingo		1930 hrs ome, farm, stree	et, factory, office i					or Rural Route Number, City
Div oital oi urs aft oral Di			ermined		Single Far	nily			50	or Town, S 020 Doppler	State) 'St., Capitol Heig	hts, MD
= $\pm z$												
To the within To the comple	Ze L	29b. Signature and title of certif		and manner sta	ited.		29c. Licens					(Month, Day, Year)
		Canel		4001	Od In		O.C.	M.E.			April 10, 200	8
1 12	r	30. Name and address of perso	n who c	ompleted cause	of death (Item	n 23a)					L	
K (3)				nt Medical E			Street, Baltim	ore, MD	21201			
Sta Registr	te ar	APR 1 7 2008	K	32. Reg	istrar's Signa							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Charles L. Moore 15, 2008 April 2:38 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6011 Emerson Street #112 **Bladensburg** Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 2 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours 241-40-7282 Director 74 Nov 17, 1933 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Director Maryland | Prince George's Bladensburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or Items 23a or adical Examiner must be r 6011 Emerson Street #112 20710 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 【No Specify Specify: **Black** þ 3 XWidowed 4 ☐ Divorced al Hygiene. I other than "natura went, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Driver <u>Private</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlie Moore Mary Bulluck 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamika L. Hainsworth/Granddaughter 2668 Chorus Ct. Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If Ite any Injury or ot 1XXQurial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 04-19-08 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC 20019 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Carcinoma of Lung 6 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and sthe burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte Year in the past 12 months? 1 ☐ Yes 2 ZNo Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Pneumonia Completed Hypertensive Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Diabetes Mellitus 2X No Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SN Residence 6 Other (Specify) 1 ☐ Yes 2X No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 17, 2008 march MD25618 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington, DC 20017 1160 Varnum Street, NE Suite 317 Lewis W. Marshall, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Bladimir Rafael M		State of Maryland / Department of Health and Mental Hy For State Certificate of Death		Reg. No.	400	0 1410
Dhysisian	R		2. Date of De	ath		Time of Death
Physician Me Examine	er	Bladimir Rafael Morel	Month April 13,		y of Death	0854 hrs
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park		Montge		
	,	Washington Adventist Hospital Takoma Park Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	. 8. Date of E	Birth(MM/DD/YY	YY) 9. Birthpl	ace (State or
Funeral Director		214-31-1931 X M 2 F 28 Yrs. Months Days Hours Min.	oct.	- 16, 19	979 Count	y) Republic
any	- 1-	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				d. Inside City Limits
*		Maryland Prince George's New Carrollton				Yes 2 X No
arylan 8a-f s	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Country SA	7?
the Manager 3	5	7307 Longbranch Drive 20784 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp.	posify Ves or			n Indian, Black,
th with	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		hite, etc.	
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urs afi tural'	황	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use retired to the during most of working life.	work done tired)	16b. Kind of	Business/Ind	ustry
6 172 hc an "ns	턀	Elementary/Secondary (0-12) College (1-4 or 5+) 11 Carpenter		Carp	entry	
21215-0036 Joint Be filed within 72 hours after death with the Maryland Mental Hygiene. Marked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	Completed	17. Father's Name (First Middle, Last) 18.Mother's Name			ime)	
215- e filed tal Hyy ked of	Be	Emilio De Jesus Morel Susana Fi		_		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 2916 Weisman Road, Sil	Rural Route N	ring, M	D 2090	2
e, M 1 and 2 Health item 2	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date oril 18		on - City or T	
mor Pages ent of nt: If		Gate of Heaven Cemetery	2008	Silve		ng,Maryland
altir rmit. I spartm sporta	1	21. Signature of Funeral Service Licensee 22 Name and Address of Facility 1 in 500 University Bl	s Fune	ral Hom	e Inc.	na. MD 2090
		23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory	arrest, shock, o	r heart	Approximate Interval Between Onset and
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Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
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760, ficate be g physic the bur	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy	Z3d. Da Mor		ay Year
cords, P.O. Box 6876 law requires that the death certificate has been signed by the attending phy 2 should be detached for use as the 6	Physician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		-		
Bo he deat the at the at red for	hys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. I	Did tobacco use	contribute to	the cause of death?
P.O.	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	Yes 2 V No	3 Prob	ably 4 Unknown
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Vital F hysician: this certifi	To Be	1 V Yes 2 No	rsing Home			r:
Division of Vital Records, tal or Attending Physician: The law requiral state death. After this certificate has been sided in by the funeral director, page 2 should t	ä.	27. Manner of Death 28a. Date of Injury (Month Day Seer) 1 Natural 5 Pendino Apr 13, 2008 ear) 28b. Time of Injury 0815 hrs 1 Yes 2 ✓ No	Subject	cribe how injury o shot	occurred	
ivision or Attend after death. Director:	catic	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Loca	tion (Street and	Number or Ru	ural Route Number, City
Divis	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	or To Missouri	own, State) Avenue @ Rig	ggs Avenue	, Washington, DC
E G E		20g Certifier at the time date and place is	and due to the	e cause(s) and n	nanner as star	ted. ne cause(s)
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred and manner stated.	ed at the time,	29d. Dat	e signed (Mo	onth, Day, Year)
	Ž	29b. Signature and title of certifier O.C.M.E.			4, 2008	
V		30. Name and address of person who completed cause of death (Item 23a)	·			
	1	30. Name and address of person who completed cause of death (tell) 233 Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	MD 21201			
S	tat	31. Date filed (Month Day, Year) 32. Registrar's Signature				
Regis		APR 16 2008 Barnes 15 199000				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Dorothy Schultz Millington 1:50 p^M April 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arden Courts Assisted Living Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 DxF Director 217-14-0880 85 28, 1922 Maryland Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be rediffed at once. 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2505 Musgrove Road 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{TNo} \) Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: ģ White 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Louis Schultz Mary Sohl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 Douglas F. Millington/Son 5629 Harpers Farm Road, Unit F, Columbia. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 15 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Dother (Specify) 2008 Alexandria, Virginia 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W. Silver Spring, <u>MD 20901</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final **Physician** Alzheimer's Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Osteoporosis Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans Hyperlipidemia resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical <u>Peripheral Vascular Disease</u> IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 □No of Vital 1 □Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify Assisted Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Living Division the Hospitai or Attending hin 24 hours after death. 1 X Natural 5 Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 121Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D20274 April 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kirti Vohra, MD 7710 Bradley Blvd., Bethesda, MD 20817 31. Date filed (Month, Day, Year) APR 1 6 2008 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Marguerite Vesta McAllister 11:00 PM 12 2008 Apri1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 101D Carter Court Ceci1 Perryville 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Days 73 Yrs. 9, 215-30-6913 **Director** 1934 D.C. Aug. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County at r 28a-f sh notified 1 XYes 2 □ No Directo Maryland Cecil Perryville 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code "natural", or Items 23a or dical Examiner must be 101D Carter Court 21903 USA death v Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 ☐ Widowed 4 X Divorced Completed th and Mental Hygiene.
7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Fred Julian Herron ဥ Marguerite Anna Pechin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Kelly Mullins/Daughter 1003 Blue Ball Rd., Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4-16-2008 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, MD 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Leensee 111 S. Queen St., Rising Sun, 21911 23a Part1. Enter the disease, or complications, or hear failure. List only one Immediate Cause (Final disease or complicion ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner 1 Haulh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician The law requires that the death certificate be Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year signed by the at 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s 1□ Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 🗌 Yes 2 🗌 No 2 Accident 24 hours after death Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 To the 29b. Signa re and title of Cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), POMILA SVET 155 W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008

DHMH 17 Rev 1/2001

Registrar

P.0. Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, t

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. St. Timothy O'Donnell Suite 32 Peoples Plaza, Glasgow, DE. 31. Date filed (Month, Day, Year) APR 3

1241

State Registrar

				For State Registrar	State	of Maryla	nd / Depa <i>Ce</i>			lealth : Death			giene 🤶	008		185
			-114	1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month		Vaar	3. Time of	Death
	Ð	Physici /Medic			Chris	tina H.	Mitche	e11				April	23	2008	2255	P^{M}
		Examir		4a. Facility Name (If not institution					Town, or	Location	of Death	_	4c. Coun	ty of Death		
				27 Hunt Valle	y Loop			E	1ktoi	n			Ce	eci1		
		Funeral		5. Social Security Number	6. Sex 1 □ M 2 X F		s. last birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da	v. Year)	9. Birthp Coun	lace (State o	r Foreign
	Е	Director		222-24-3224	1 M 2 A JF	68	Yrs.					July 10	, 1939	De1	aware	
		and w		Usual Residence of Decedent 10a. State 10b. County		10c (City, Town or Lo	ocation						1	0d. Inside Ci	tv Limits
		sho sho	5	,				, odilon						'	1 □Yes	
		the N	Director	Maryland Cec	11		E1kton	404 7	0 1				10- Oiti	. 14/1 4 0		n
		with the ben		10e. Street and Number	D 1			10f. Zij					10g. Citizen o		•	
—		be filed within 72 hours after death with the Maryland that Hygiene. And Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	77 Lewisville		and and Francis	110		1921		1-1-0 (0-			ced St		
[e]		er de Item	Š	11. Marital Status 1 □ Never Married 2 □ Man	Armed F	cedent Ever in Forces? 2 X No	0.5.	If Yes, spe	cify Cuba	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	- 14. H	ack, White,		
다.	36	rs aft		3 Widowed 4 Divorced	If Voc C	Bive		1 ☐ Yes	2 X No	Specify:			Spec	ify: Lih	ite	
Mitchel	5-0036	tura al E	pa		t's Education	Datos.	16a. Dece	dent's Usu	al Occup	ation			16b. Kind of			
	215	in 72 i "na ledio	olet	(Specify only highe	st grade completed		(Give	kind of wo	ork done o	during mos	st of work	ing	100111111111111111111111111111111111111	Dadii 1000/III	2400, 7	
in	212	filed within Hygiene. other than "	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Boo	kkee	per				Hard	lware	Store	
St		Hygid Hygid Sther ent, th	Ö	17. Father's Name (First, Middle,	Last)					18. Moth	er's Name	e (First, Middle,			00010	
Christina	Maryland	ould be Mental arked o	To Be Completed by	Charles Walter	Hawke					Ge	rtru	de Jone	s			
5	ΞŽ	should ind Men s marke umatic	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Addres	s (Street		_	al Route Numb		n, State, Zip	Code)	
	Š	nd 2 alth a 27 is r trau		Katherine A. H	Burns/Dau	ghter	27 Hı	int V	aller	z I.oo	n. E	lkton,	MD 219	121		
	ō,	es 1 and 2 should be of Health and Mental fitem 27 is marked or r other traumatic eve		20a. Method of Disposition		20b	Place of Dispo	sition (Na	me of			Date	20c. Location		wn, State	
	Baltimore,	permit. Pages Department of the Important: If its any Injury or of once.		1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (S		n State R.	-			· ; r	aprij 2008	24,	West (hosto	r PA	
	₹	nit. I		21. Signature of Funeral Service										JIESCE	i, in	
	ä	Depa Impo any Ir		America.	Q 41;	Cado	H	icks N3 W	Home	cktor	Fune Str	erals, E	kton	MD 21	.921	
		777		23a. Part1. Enter the disease, or	complications that	caused the de									Approximat Interval Bet	е
		Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.		. /	00	01	1	0		- 1	Onset and I	ween Death
€)	/Medical		disease or condition resulting in death)	a. Due to	o (or as a conse		ויינט	0	ell	L	us Cu	con			
		Examiner				,						4				
	1		Je.	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. Dust	(ur de a curie	aquerioe of):									
		cuted id ansit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
	Ó	te be executed ysician and e burial-transit		resulting in death) Last	Due to	o (or as a conse	equence of):									
	3760,	ate be nysici he bu	ical		d											
	Box 68	or Attending Physician: The law requires that the death certificate iter death. Iter death. Iterator: Atter this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE:												
	<u>@</u>	ath ce tendi	an/	23b. Was decedent pregnant in the past 12 months?		utcome pf preg birth 2□Fe		⊒Ectopic p	regnancy	/				ate of delive Month	,	Vaar
		e dez	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	gnant at time of nown	f death 5[Other (s	pecify)				'	AOHH	Day	Year
	P. 0	ires that the de signed by the a I be detached f	Ph			d a a b la cata a a b a a		and and other and						. 4 - 7		0
	ŝ	res the igner be d	þ	Part II. Other significant conditi	ons contributing to	death but not re	esulling in the u	naenying o	ause giv	en in Part i		23e. Did t	obacco use co			
	9	w require been si	ted										res Z No	3 Prot	ably 4 ∏l	Jnknown
	ec	ne law has b ge 2 sl	aldr.									24a. Was auto	DSV	. Were auto	psy findings mpletion of c	available ause of
	=	The cate has page	Completed										rmed?	death? 1 ☐ Yes	2 No	
;	ĬĘ	iclan: Th certificate ector, pag	Be	25. Was case referred to medica examiner?								h (Check only o			Your bt	1-
1	7	hysi this o	ပ္	1 Yes 2 No			☐ ER/Outpatier				ursing Ho	me 5 ☐ Resi	dence 6 🕅 C	ther (Specif	Resid	er s ence
	Ĕ	Ing F	ii o	27. Manner of Death 1 ☑ Natural 5 ☑ Pendir	ig (Mc	e of Injury onth, Day Year)	28b. Time o		28c. Injur Worl			28d. Describe	how injury occ	urred		
	Si Si	tend eath. tor: / the f	cati	2 Accident investigned investigation investigned investigation investigat	not ho			M		Yes 2						
	Division or Vital Records,	or At fter d Sirect In by	Certification:	4 ☐ Homicide determ	sinod Zoe. Plac	ce of injury - At ding, etc. <i>(Spe</i>	home, farm, sti cify)	reet, factor	y, office			28f. Location (: City or To		nber or Rura	I Route Nun	nber,
1		urs al														
		To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certification to the funeral director, to mpletely filled in by the funeral director,	Medical	29a. Certifier 1. Certifyir (Check only one) 1. Medical	ng Physician: To the Examiner: On the	basis of exami	nowledge, deat ination and/or ir	h occurred vestigation	at the tir n, in my c	ne, date a pinion, de	nd place, ath occur	and due to the red at the time,	date and plac	manner as s e, and due to	tated. o the cause(s	5)
		the the	Med	29b. Signature and title of certifie		nner stated.		20	c Licens	e number			29d. Date sign	and (Month	Day Voor	
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	•			1/1/90	qui				<u> </u>	906	$\mathcal{O}_{\mathcal{C}}$)	4/27	08		
				30. Name and address of person					C.	1	0/	E11	/ (1021		
		-01		Martha Hosfor		III W.		rreet	, su	тте]	.04,	LIKTON	, MD 2	1921		
		Sta Registr		APR 3	n 2008	Januar -	H A	ALL S	D							
9	DHI	MH 17 Rev 1/2		חווע	0 2000	and the state of t	19	100					_			
5	-111		JU 1				0	RIGINA								
DI							O1		-							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 5:20 aM April 14 2008 Kim Chi Nguyen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 1007 Venice Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 X F Vietnam 729-09-0881 February 12,1957 51 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 U.S.A. 1007 Venice Drive Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗷 No Specify. Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 🕱 Divorced Year or Dates: Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ba Thi Huynh Quy Van Lam 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1007 Venice Drive, Silver Spring, Maryland 20904 Ngoc Ngo - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 04/16/2008 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) Fort Lincoln Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Lic nsee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme ia e Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last que to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician or use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? 5 ☐ Other (specify) 2 No ed by the Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has 2 No certificate 1 🗆 Yes Division or Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3∐ DOA 1 🗌 Yes 2 28d. Describe how injury occurred completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27, Manner of Death Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as occurred at the time, date and place, and due to the cause(s) and mainter as occurred at the time, date and place, and due to the cause(s) and mainter stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D66611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shalini Dogra, M.D., 1400 Forest Glen Road, Suite 435, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) Registrar's Signature State APR 16 2008

DHMH 17 Rev 1/2001

Registrar

			Please	State of Ma	ryland / Dep	artment	of Health and		-	_	14187
			Registrar		Ce	rtiticate	of Death		Reg	. No	1-7101
	Physic /Medi		DoRoThy	Nich.	olson				Date of Death Month	Day Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give			4b. City, To	own, or Location of De	eath		4c. County of Dea	ith
н			South Pure	& Rehal	Center	Fol	gewater		Į	Anne 1	Arundel
	Funeral Director		5. Social Security Number 6. S	1	(In yrs. last birthday,	If Under 1 Months	Year If Under 24 h	lin.	Date of Birth (Month, Day, Y		thplace (State or Foreign ountry) Maryland
	P .		Usual Residence of Decedent								T
	e-f show	ctor	Maryland 10b. County Anne Ar	rundel	10c. City, Town or L	ocation	Riva				10d. Inside City Limits 1 ☐ Yes 3 ☐ No
	th with the 23s or 28	al Director	10e. Street and Number 2802 White House	e Road		10f. Zip C	21140		10g	. Citizen of What C	
	deat	Funeral	11. Marital Status	12. Was Decedent E	ever in U.S. 13.	Was Decede	nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify	Yes or No-	14. Race - Am	
036	72 hours after death with the Maryland "netural", or items 23a or 28e-1 show dical Examiner must be notified at	ğ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2420N If Yes, Give Year or Dates:	0	1 ☐ Yes 2		леко ніс	an, etc.)	Black, Whi	
215-0	- 1	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5-	16a. Deca (Give life.		Occupation done during most of retired)	working	16	b. Kind of Business	
7	d with giene. or ther	Ö	12			Homei	naker			Own I	Home
Maryland 21215-0036	should be filed withir nd Mental Hygiene. marked other then imatic event, the M.	To Be C	17. Father's Name (First, Middle, Last) George Benhoff					Name (F Cy Cr	irst, Middle, Ma One	iden Surname)	
	12 should heard 7 is muttenum		19a. Informant's Name/Relationship (Robert Nicholson)				Street and Number or L Drive I		oute Number, Co s, Delaw	•	
Baltimore,	of of		20a. Method of Disposition 1 □ Burial 2 XCremation 3 □ 1 □ Donation 5 □ Other (Specification 5 □ Other (Specification)		20b. Place of Disponentery, cre Baltimore	matory or oth	er place)	Date /12/2		c. Location - City or	Town, State Maryland
₹			21. Signature of Funeral Service Licer				Address of Facility				<u> </u>
Ba	permit. Departr Importe any inju			Nil							s, MD 21401
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each line							Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	consequence of):	pert	encist	\sim			
o î	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of):						
68760,	ificate be g physicia as the bu	edical	(d							
.O. Box	The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death 3	⊒Ectopic preg ⊒ Other (spec				23d. Date of de Month	olivery Day Year
ds, P	uires that signed b	þ	Part II. Other significent conditions of	ontributing to death bu	t not resulting in the u	ınderlying cau	se given in Part I.				o the cause of death?
of Vital Records,	ne law require has been si ge 2 should I	Completed							24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
<u> </u>							 		1 ☐ Yes 2	No 1 ☐ Yes	s 2□ No
Ĭ	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Death (C	heck only one)		
5	y s	ို	1 Ves 2 No	1 Inpatier	nt 2 ER/Outpatie					e 6 ☐Other (Spe	ecify)
	ding After fune	ation:	27. Manne of Death 1. Natural 5 □ Pending 2 □ Accident investigation		Year) 28b. Time of Injury	M 280	the line in the l	28d	. Describe how	injury occurred	
Division	를 를 들	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, st . <i>(Specify)</i>	reet, factory, o	office	28f.	Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	the Hospitel hin 24 hours of the Funerel upletely filled	edicai	29a. Certifier t⊅ Certifying Ph (Check only one) 2 ☐ Medical Exam	y sici en: To the best o niner: On the basis of and manner stat	examination and/or in	h occurred at vestigation, in	the time, date and plan my opinion, death o	ace, and ccurred a	due to the causat the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
)	To the within 2 To the complet	M	29b. Signature and tipe of certifier	he	M'(29c.	icense number	13	29d	Date signed (Mon	th. Day, Year)
1	5ch		30. Name and address of person who	completed cause of de	eath (Item 23a) Type	Print) L	inden	Ave	- Bar	(hmore	2/201
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 1 2	32. P gistra	r's Signature	book	•			,	

			¶ ⊷ For State Registrar		Marylan	_	artment of F			Reg. No.2	008	14188
	Physic /Medi		Decedent's Name (First, Middle, I David I	ast) E. Oakley					2. Date of De Month April	Day	2008	3. Time of Death 4:15 p ^M
	Examir	er	4a. Facility Name (If not institution, g Larkin Case-Hark	orside H	ealth (4b. City, Town, o Bowie			Prin	nty of Death	
	Funeral Director		578-86-7078	Sex 7 1 XM 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	Sirth Pay, Year) 9. Birthplace (State or For Country) 1 Jamaica		
	death with the Maryland ms 23a or 28a-1 show	ctor	Usual Residence of Decedent 10a State Prince	Georges		y, Town or Lo				•		0d. Inside City Limits 1 ✓ Yes 2 ☐ No
	th with th	al Director	4505 41st Ave				10f. Zip Code	20722		10g. Citizen Jama	of What Cour nica	ntry?
980	rs after I', or ite	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	2 ₹ No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		Race - Americ Black, White, ecity: Blac	etc.
Maryland 21215-0036	c · 3	Completed	15. Decedent's (Specify only highest g		4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Odian	ation during most of w	orking		f Business/Ind	
rland 2	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Max	To Be Co	17. Father's Name (First, Middle, Latunk	st)		Case	OCIAII	18. Mother's Na unk	ame (First, Middle,	ika i c		
, Mary	and 2 sho ealth and t m 27 is ma		19a. Informant's Name/Relationship Sharon Oakley	_(Турв, Print) daught	er	19b. Maili 54 Pr	ng Address (Street iory Rd.	and Number or F Hornsey	Rural Route Number , London	or, City or To N87EX	wn, State, Zip	Code)
Baltimore,	Pages 1 and ment of Health ant: if item 27 ury or other tr		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Date il 17,200		on - City or To uel, Ma					
Balt	permit. Pages Department of important: if if any injury or once.		21. Signature of Puneral Service Lic	ensee) Oud	1_	9	2. Name and Addres	ss of Facility R	endon/Hai Lanham	le Fund , MD 2	eral Ho	ome
8760,	Physician /Medical Examiner be executed but a science of the putial transit	dical Examiner	23a. P.n.t. Enter the diseas, or shock, or heart failure. Shock, or heart failure. In mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respi Due to (o b. Gener Due to (o c. Demen	ratory ras a consequence ras a consequence ras a consequence	Failu uence of): ility uence of):		g, such as cardi	ac or respiratory a	ilest,		Approximate Interval Between Onset and Death
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rds, P.	quires that the de n signed by the a uld be detached f	d by Pl	Part II. Other significant conditions cardiomyopathy	contributing to dea	th but not resu	ulting in the u	nderlying cause givi	en in Part I.		obacco use c		ably 4 Unknown
Records,	. The taw requir ate has been si page 2 should I	Completed by	Hypertension Prostate Cancer	· · · · · · · · · · · · · · · · · · ·				-	24a. Was autop perfo	an 24 osy rmad? 20 No	death?	psy findings available inpletion of cause of
of Vital	ysicien: is certific director.	To Be C	25. Was case referred to medical examiner? 1 Yes No	Hospitat: t ☐ Ing	patient 2	ER/Outpatier	t 3 DOA Oth		eath Check only o	ne		
Division o	or Attending fter death. birector; After n by the fune	Certification:	27. Manner of Death	be 28e. Place o		28b. Time of Injury	Worl		28d. Describe h	now injury occ	curred	l Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director; completely filled in by the	edical C	29a. Certifier 1 Certifying F	hysician: To the b miner. On the bas and manne	is of examinat	wledge, deatl tion and/or in	n occurred at the time vestigation, in my of	ne, date and place pinion, death occ	e, and due to the surred at the time,	cause(s) and date and plac	manner as st	ated. the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	zy.	my		29c. License D004				ned (<i>Month, L</i> 7, 20	
1	Sta	te	30. Name and address of 5 fson who Dr. Ajayi 620	Greenbe.	of death (Item Lt Rd. gistrar's Signal	#U-15	College	Park, M	1D 20740			

DHMH 17 Rev 1/2001

08-02	2683	
Fred	Perkins	

in Black Indelible Ink Ensure All Copies Are Legible

Derkins		State of Maryland / Department of Certificate of Ce	f Health and Mental Hygiene
Physicia		1- For State Certificate 0. Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death
dical Exami	ner	FRED PERKINS	April 5, 2008
		4a. Facility Name (if not institution, give street and number) Prince George's Hospital	4b. City, Town, or Location of Death Cheverly 4c. County of Death Prince George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		$ 577-72-2098 _{1 X_{M}} _{2 F} 54 _{Y_{T}}$	Months Days Hours Mill. 0 /2 /52
, h		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	tion 10d. Inside City Limits
T Toward		10a. State	1 Yes 2 No
aryland 8a-f st	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
with the Maryland ns 23a or 28a-f show any be notified at once.		12404 CHASEMOUNT CT.	20720 U.S.A. (as Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
th with tems 2:	Funeral	1 Never Married 2 Married Armed Forces? If	/as Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. BLACK
her dea		1 Yes 2X No 1 Yes 2X No 1	Yes 2 ^X No specify: Specify:
ours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede during	ent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)
336 thin 72 ho ne. than "ns tedical Ex	plet	Elementary/Secondary (0-12) College (1-4 or 5+) 3 ENG	INEER SUPERVISOR WALTER REED HOSPITA
5-0036 iled within 72 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname) EVA GARDNER
21218 buld be fill Mental H marked	Be	NELSON HALL	ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 2 id 2 should lith and M m 27 is m	۵	GAIL PERKINS/WIFE 1240	4 CHASEMOUNT CT. BOWIE, MD 20/20
		crematory or	osition (Name of cemetery, Date 20c. Location - City or Town, State other place)
Pages nent of ant: 14		4 Donation 5 Other Specify:	CTION CEM: 4/14/08 CLINTON, MD
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr	1	21. Signature of Function Convicts Econocc	Name and Address of Facility STRICKLAND FUNERAL SERVICE 500 ALLENTOWN RD. CAMP SPRINGS, MD 207
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and
Medica	0 0	failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Gunshot Wounds	Death
amine		or condition resulting in death) Due to (or as a consequence of):	
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examine	C. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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O, e be exertision sician burial -	edic	UNPENDED AMENDED	23d. Date of delivery
tox 68760, eath certificate be attending physici for use as the buri	an/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy Month Day Year
Box 6 death cer the attend	2	7 Yes 2 No 9 Unknown	Other (Specify)
m P ž z	≀ 1 7	Part II. Other significant conditions contributing to death but not resulting in the	
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cords law requir	Plate		autopsy prior to completion of cause of performed? death?
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/ital /sician:	8		Othor
1 of Vital Records, ing Physician: The law requir After this certificate has been a	ē F	27 Manner of Death 28a, Date of Injury 28b, Time	l Police involved shooting
ttendii death.		Natural 5 Pending Apr 5, 2008 0906 hrs	
Division tal or Attendirs after death.	Tilled in by the tune	Accident Suicide Could not be determined (Specify) Bank	or Town, State) 13000 Annapolis Road, Bowie, MD
id on	>	Z98. CEILIEL A List - Structules. To the best of my knowledge deeth of	occurred at the time, date and place, and due to the cause(s) and manner as stated.
o the o	completely	one) 2 Medical Examiner:On the basis of examination and/or investant manner stated.	tigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
FSF	` غ	29b. Signature and title of certifier All All A	29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 6, 2008
		30. Name and address of person who completed cause of death (Item 23a)	
0		Carol Allan, MD Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 21201
	Sta		
Reg	istr		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 12:50 A 9, 2008 April James W. Pryor /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 3115 Lake Avenue Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 X M 2 □ F 213-40-8143 Oct 19, 1939 Minnesota Director 68 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1X Yes 2 □ No Director Maryland Prince George's Cheverly 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 USA 3115 Lake Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give 1960 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: **≥** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Building Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Earl Pryor Elsie Carol Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3640 Lexington Turnpike, Amherst, VA Kenneth Allen Pryor - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Metropolitan Crematory 4/12/2008 Alexandria, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility 4739 Baltimore Ave. tonslance Hyattsville, MD 20781 /Jas Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial infarction Acute Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of) physician Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1☐ Yes

Physician /Medical Examiner

the Maryland

altimore, Maryland 21215-0036

page 2 funeral director

Completed certificate Be Certification: To this After after death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed

the

Division or Vital Records, P.O. Box 68760,

0 8 a (2)

Dr. Luis A. Casas APR 1 1 2008 State Registrar

25. Was case referred to medical examiner?

5 Pending investigation

6 ☐ Could not be

determined

1 ☐ Yes 2 🔀 No

27. Manner of Death

1 XNatural

2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

IM

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

28a. Date of Injury (Month, Day Year)

29c. License number

D24997

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

20707

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 4/9/2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8317 Cherry Lane, Laurel, MD

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Injury

31. Date filed (Month, Day, Year) State APR 1 7 2008 Registrar

29b. Signature and title of certifier

300 PLE

TERRY JODRIE, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D40324

7503 SURRATTS ROAD, CLINTON, MAPYLAND 20735

29d. Date signed (Month, Day, Year)

APAIL 6, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 13, 2008 6:20 A M **Physician** REESE PARKER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Gaithersburg Wilson Health Care Center 8. Date of Birth (Month, Day, Year) Nov. 26,1916 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1**X** M 2□ F 91 Maryland 217-18-4655 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10b. County iten 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Montgomery Gaithersburg MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 333 Russell Ave. #415 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give WWII Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Banking Chief Financial Officer 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event 17. Father's Name (First, Middle, Last) Lucretia Hutson Robert Reese Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 333 Russell Ave. #415 Gaithersburg, MD 20877 Wilma Ryan Parker (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 15, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crem. Alexandria, VA 4 Donation 5 DOther (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that cave of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) adays Due to (or s a consequence of): Physician /Medical Examiner Alekelner arrendo 2 Sequentially list conditions, Due to for as a consequence of day, leading to Immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Peripheral Neuropathy 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No MusipionytogyH 24a. Was an autopsy performed? res 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 April 13, 2008 041794

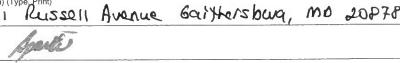
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State Registrar

31. Date filed (Month, Day, Year) APR 16

Name and address of person who completed cause of death (Item 23a) (Type, Print)





			State of Maryland / Dep	artment of Health and Mental Hyg	iene
			- negistrar		b 3. Time of Death
	Dhamisi		Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year
	Physicia /Medic		Edsel Bruce Potter	April 22	
13	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3.		- 16 Sec	Calvert Memorial Hospital	Prince Frederick	Calvert
1960	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day,	9. Birthplace (State or Foreign Country)
	Director		225-20-0780 1XM 2□F 83 Yrs.	08/18/19	024 Virginia
	ס		Usual Residence of Decedent		10d. Inside City Limits
	ylan		10a. State 10b. County 10c. City, Town or I	cocation	1 ☐ Yes 🏖 No
	Ma-f-	5	Maryland St. Mary's	California	1 103 #5110
	r 28	by Funeral Director	10e. Street and Number	10f. Zip Code	0g. Citizen of What Country?
	38 c		23198 Oak Drive	20619	United States
	deatl	er	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
10	in the	T.	1 Never Married 2 Married 1 M Yes 2 No	1 ☐ Yes 2 No Specify:	Specify: White
ဗ္ဗိ	ars a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 Yes 2124 No Specify:	<i>Specily:</i> ИПТСС
ŏ	72 hours after death with the Maryland natural; or itema 23e or 28e-f ehow creat Examiner suits be notilied at	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
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212	thene	E O		sing Inspector	U.S. Government
Maryland 21215-0036	filed Hyg othe	a)	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Maiden Sumame)
an	d be ental ked o	To B	Vennie Marcelus Potter	Carrie Belle Po	ounds
2	mari mari	-		iling Address (Street and Number or Rural Route Number	r, City or Town, State, Zip Code)
<u>≅</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or itema 23a or 28a-f show any righty or other traumatic event, the Mactical Examinat		Angeline E. Potter / Wife 2319	8 Oak Drive, California, N	Maryland 20619
	1 an Heal Brn 2 thar		20a. Method of Disposition 20b. Place of Dis		20c. Location - City or Town, State
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Baltimore,	Departiment Important		73/4	22. Name and Address of Facility Brinsfield	
ш	<u>v</u> ⊽= = a			2955 Hollywood Rd., Leonar	
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac or respiratory arr	est, Approximate Interval Between Onset and Death
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	/Medical		resulting in death) Due to for as a consequence of):		
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× 6	leath certifica attending ph I for use as t	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box	atten atten for u	lan	23b. Was decedent pregnant in the past 12 months? 1	☐ Other (specify)	Month Day Year
	by the darket	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Janes (speeding)	
P.0	that the ed by detac	Ph	Part II. Other significant conditions contributing to death but not resulting in the	sunderlying cause given in Part i. 23e. Did to	bacco use contribute to the cause of death?
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S	as be	ple	Atrial tibrillation, coronary	autop	sy prior to completion of cause of
ď	The tare has page	TO.	Octeomiel Tis of foot, periphe	ral vascular disease 10 yes	med? death? 2 DNo 1 □ Yes 2 DNo
ta	icien: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death (Check only o	ne)
Division of Vital Records,	8 W D	To B		ient 3 DOA Cther: 4 Nursing Home 5 Resid	lence 6 □Other (Specify)
0	ding Phy n. After thi funeral c				ow injury occurred
Ö	th. : After e funer	100	1 Datural 5 Pending (Month, Day Fear) Injur	M 1 Yes 2 No	
/isi	l or Attanuatter deatl	flea	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office 28f. Location (S City or Tow	Street and Number or Rural Route Number,
<u>S</u>	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City of You	m, state)
_	pita ours aral filled			eath occurred at the time, date and place, and due to the	cause(s) and manner as stated.
	To the Hospital or Attant within 24 hours after deatl To the Funaral Director: completely filled in by the	edical	(Check only 2 Medical Examiner: On the basis of examination and/or one)	investigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
	thin the mple	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	T W O		No ma	016300	04/23/2008
			7 41() 100	060390	01/23/2006
			30. Name and address of person who completed cause of death (Item 23a) (Typ		0 0 1 7 9
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		ate			
	Regist	rar	APR 2 5 2008 Page 15 Aprile	, , , , , , , , , , , , , , , , , , , ,	

DHMH 17 Rev 1/2001

08-03138 Joseph Penn, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 | 4 | 94 1- For State Certificate of Death Rea. No. Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 23, 2008 0620 hrs Medical Examiner JOSEPH PENN, JR. c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Somerset McCready Hospital Crisfield 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Davs Hours Min. Director Country) 151-54-4543 June 2, 1957 50 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits nn, 10a. State 10b. County 10c. City, Town or Location Maryland Somerset Crisfield tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No DEAILTMORE, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is mental. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Myrtle Street 21817 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 X Married 2 X No Yes White If Yes, Give Year Yes 2 X No specify: Widowed 4 Divorced Specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractor 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ruth Louise Taylor Joseph L. Penn, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1004 Myrtle Street - Crisfield, MD 21817 19a. Informant's Name/Relationship (Type, Print) ဥ 404 Myrtle Street - Crisfield, MD Rae Dawn Penn (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 4/28/08 Salisbury, MD Salisbury Crematory Donation 5 Other Specify 22. Name and Address of Facility
Bradshaw & Sons Funeral Home 21. Signature of Fineral Service Lic 306 W. Main St.- Crisfield, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Endocarditis with complications Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Records, P.O. Box 68760, The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial - transi Physician/Medical X UNPENDED #23a.27.perME.2879 5/13/08 TT 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Dav Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been s. page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate has performed? ✓ Yes 2 No 1 🗸 Yes ospital or Attending Physician: hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be Other: examiner? Hospital: Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 this 1 🗸 Yes ٩ After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division Yes 2 Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined the Hospital To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Sa within 2 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 24, 2008 a 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

_			For State Registrar		State of I	vlarylan		artment of F rtificate of		d Mental F	lygiei Reg.	211	08	14195	
	Physici	an	1. Decedent's Name (First, A	liddle, La						2. Date of Month		Day	Year	3. Time of Death	
	/Medic Examir	cal	EUGENIA 4a. Facility Name (If not instite)	ution air	QUIRE	ar)		4b. City, Town, o	r Location of De	APRI		15, 20 4c. County	008 of Death	8:50 A. ^M	
7	Examir	ler	SHADY GROVE			*		ROCKV				MONTG(•	
	Funeral		5. Social Security Number	1	Sex 7. 1 □ M 2 □ X F		last birthday)	If Under 1 Year Months Days	If Under 24 H					lace (State or Foreign try)	
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	e Mar sa-f sh tified	ctor	MD MON	GOMI	ERY	GA]	THERSE	BURG					_	1X1Yes 2 □ No	
	vith th	Director	10e. Street and Number	men				10f. Zip Code			10g.	Citizen of W	Vhat Coun	try?	
	eath v	Funeral	8739 KELSO	IER	12. Was Decede	nt Ever in U.	S. 13.V	20877	lispanic Origin?	(Specify Yes or		BERIAL 14. Race	N e - Americ	an Indian.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fun	1 Never Married 2 3 X Widowed 4 Divo		Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ∑No		Was Decedent of H f Yes, specify Cuba l □ Yes 2√√ No	Specify:	ierto Rican, etc.)	110	Black	k, White,	etc.	
2-0	72 ho natur dical l	eted	15. Dec	dent's E	ducation ade completed)		16a. Deced	lent's Usual Occup	ation during most of v	workina	16b	. Kind of Bu	siness/Ind	lustry	
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lan	should be filed vand Mental Hygie marked other i umatic event, th	To Be	DOE	Q	JIRE				NYANC	R BROWN					
lary	2 should I and Men Is marker aumatic		19a. Informant's Name/Rela	ionship ((Type. Print)		19b. Mailir	g Address (Street	and Number or	Rural Route Nu	mber, Cit	ty or Town,	State, Zip	Code)	
	t and tealth sm 27 ther tr		MEKI LITTELL/ 20a. Method of Disposition	DAUC	HTER	20h E		COCHRANE sition (Name of	CT., G	AITHERS Date					
nor	Pages nent of H ant: If ite ury or of		1 ☑ Burial 2 ☐ Cremat			te C	remetery, crer	natory or other place HEAVEN		-	1	Location -	•	m, state D, MD.	
Baltimore,	ナモゼラ		4 □ Donation 5 □ Oth			0/1/		. Name and Addre		3/08 CAPITOI				n, m.	
ä	permi Depar Impor any ir	ı h	Show	1//	mons	fall	ey 1	425 MARY	LAND AV	E., N.E.	. WAS	SH., I		20002	
E			23a. Part1. Enter the diseas shock, or heart failure.	e, or com List only	plications that cause on each	sed the deatl	n. Do not ent	er the mode of dyir	ig, such as card	diac or respirator	y arrest,			Approximate Interval Between Onset and Death	
	Physician //Medical		Immediate Cause (Final disease or condition resulting in death)		_a	<i>I</i> ARIAN		CER							
	Examiner			- (Due to (or	as a conseq	uence of):								
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	J	b. Due to (or	as a conseq	uence of):								
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68760,	tificate be executed ig physician and as the burial-transit	al E	,	ı	Due to (or	as a conseq	dence oi).								
687	ificate g phys as the	edical			d										
P.O. Box	death cer e attendin d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown		23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	2 ☐ Feta t at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	′		_	23d. Date Mor	e of delive	ry Day Year	
	The law requires that the ate has been signed by the bage 2 should be detache	by Pr	Part II. Other significant cor	ditions	contributing to deat	but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. D	id tobacc	co use contr	ribute to th	e cause of death?	
or Vital Records,	w require been sig should b	ted								- 1	☐ Yes	2₩ No	3 Prob	ably 4 ☐Unknown	
3ec	e law has b	Completed								_ 24a. W	utopsy	l p	orior to cor	osy findings available npletion of cause of	
le	n: Th ficate rr, pag		OF Man agen referred to me	dianl	T					1□ Ye			death? I □ Yes	2 X No	
=	/sicia s certi firecto	o Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☐ No	uicai	Hospital:	atient 2 🗀	ER/Outpatien	t 3CLDOA Oth	or.	Death <i>(Check on</i> g Home 5 ☐ R		6 DOth	os (Engais	4	
סר	ig Phy ter this neral c	n: To	27. Manner of Death	- 4:	28a. Date of I		28b. Time of Injury					njury occurr		<u></u>	
Sior	Attending Physician: r death. ector: After this certific by the funeral director,	atio	E . / tooldont	nding estigation uld not b	n			M 1	Yes 2 □ No						
Division	tai or Att s after de al Direct ed in by	Certification:		termined	Zoe. Place of	injury - At ho etc. <i>(Specif</i>)	ome, farm, str V)	eet, factory, office		28f. Locatio City or	n (Street Town, St	t and Number tate)	er or Rura	l Route Number,	
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier 1 Cert (Check only) 2 Med	ifying Pl ical Exa	nysician: To the be miner: On the basi and manner	of examina	wledge, deatl tion and/or in	n occurred at the tirvestigation, in my o	ne, date and pl	ace, and due to ccurred at the tir	the cause ne, date	e(s) and ma and place, a	nner as st and due to	ated. the cause(s)	
	To the within 2	Σ	29b. Signature and title of ce	rtilier	0			29c. Licens	e number		29d.	Date signed	d (Month,	Day, Year)	
	10		Melvel	JA	JULY,	4			4615		4/	15/08			
2	(2)		30. Name and address of pe GENEVICVC WR		completed cause of WSKI 97			Print) CENTER DE	IVE ROC	CKVILLE.	MD.	2085	0		
2	Sta Registr		31. Date filed (Month, Day,) APR 1 7 200	ear)	32. Regi	strar's Signa	ture								

DHMH 17 Rev 1/2001

1 - For State Registra 1. Decedent'

29a. Certifier

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic.

Physician /Medical Examiner Be Completed by Funeral Director

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Examine

Medical Certification: To Be Completed by Physician/Medical

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For State		otate of Ma	-		tment of F ificate of	lealth and I Death			000	0 11 100
Registrar	(First, Middle, Last)		-	JUI (I	ncate of	Dealli	2. Date of Dea	leg. No.		3. Time of Death
			rarm a ro				A Month	7 Day	2 (Year	82.44am
	LAS JOSEI not institution, give str		ETAR		4b. City, Town, o	r Location of Death	MAIN	4c. C	county of Dea	oth
Civista	Medical	Cent	25		Lo	Plate	2		Char	-les
5. Social Security N			e (In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Bir	thplace (State or Foreign
219-74-	0051	/ 2□F	55 ^Y	rs.			3-2-1	953	PA	
Usual Residence of 10a. State	10b. County		10c. City, Town	or Loca	tion					10d. Inside City Limits
MD.	CHARLES	5	I	LA I	PLATA					1 ☐ Yes 2 No
10e. Street and Nur	nber				10f. Zip Code			10g. Citiz	en of What Co	ountry?
P.O.BO	X 488				206	546		U.S	.A.	
11. Marital Status	12	. Was Decedent I Armed Forces?	Ever in U.S.	13. W	as Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecity Yes or No- o Rican, etc.)	1-	4. Race - Ame Black, Whi	
	ed 2 Married	1 Yes 2 K	10		JYes 25√2 No	Specify:	,		Specify: WH	
3 Widowed		Year or Dates:	160		nt's Usual Occu	nation			d of Business	
	15. Decedent's Educa	completed)		(Give ki life. DC	nd of work done NOT use retire	during most of wor d)	king	TOD. KIII	J OI DUSINESS	vindustry
Elementary/Seco	ndary (0-12)	College (1-4or 5	+)	DIS	SABLED			NON	ΙE	
17. Father's Name ((First, Middle, Last)		•			18. Mother's Nan	ne (First, Middle,	Maiden S	Gurname)	
MICHA	EL RESHE	ľAR				ANNA N	IICHALY	SHIN	T	
19a. Informant's Na	ame/Relationship (Type	e. Print)		_	'	and Number or Ru		er, City or	Town, State,	Zip Code)
	N HAYDEN-	-SISTER				B LA PLA		206		
20a. Method of Disp 1 XBurial 2 I	osition ☐Cremation 3 ☐Rei	moval from State	20b. Place of cemetery	r, crema	itory or other pla		Date		ation - City or	
4 Donation	J L Other (opcony)		.MARY'S		KRANIAI		1-29-08			PA.
21. Signature of 50	ineral Service Licensee	M0047	9	È	Name and Addre AYMOND A PLATA	FUNERAI FUNERAI A, MD. 20	SERVI	CE, E	P.A.	
23a. Part1. Enter the shock, or hea	he disease, or complicant failure. List only one	ations that caused cause on each lin	the death. Do no	ot enter	the mode of dyi	ng, such as cardiad	or respiratory ar	rest,		Approximate Interval Between
Immediate Cause (Final		5	E	PSI	S				Onset and Death
resulting in death)	T a.	Due to (or as	a consequence o	f):						
Sequentially list con	nditions, b.									
if any, leading to im cause. Enter Unde	nmediate erlying	Due to (or as	a consequence o	f):						
that initiated events resulting in death) I	ast c.	Due to (or as	a consequence o	f):						
	•	240 10 (0) 40	a bonocquoneo o	.,.						
	d.									
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	c. If yes, outcome 1 □Live birth 4 □Pregnant at 9 □ Unknown	2 Fetal death		ctopic pregnand Other (specify) _	у		2	3d. Date of de Month	elivery Day Year
Part II. Other signif	ficant conditions conti	ibuting to death b	ut not resulting in	the unc	lerlying cause gi	ven in Part I.	23e. Did to	bacco us	e contribute t	to the cause of death?
D	OWN'S	SY	NDR	OM	E		1 🗆 Y	res 2	(No 3□F	Probably 4 Unknown
D	EMEN	TIA					24a. Was autop perfo 1 Yes		death?	autopsy findings available completion of cause of
25. Was case refer examiner?							ath (Check only o	ne)		
1 ☐ Yes 2	140	spital: 1 npatie			3□ DOA Ot	ner: 4 🗆 Nursing H	lome 5 ☐ Resid	dence 6	□Other (Sp	ecify)
27. Manner of Deat 1 Natural 2 Accident	th 5 ☐ Pending investigation	28a. Date of Inju (Month, Da		ime of ijury	28c. Inju Wa	nyat nk?]Yes 2∐No	28d. Describe h	now injury	occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injuding, et	ury - At home, far c. (Specify)	m, stree	et, factory, office		28f. Location (5 City or Tox	Street and vn, State)	Number or F	Rural Route Number,

To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar been signed by the should be detached within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s

29b. Signature and title of certifier

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 4-23-2008 26064

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VEDYASAGAR

WHITE PLAINS, MD 20695

State Registrar

31. Date filed (Month, Day, Year) APR 3 0 2008



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 09:54 RM 17,2008 4171211 Otis Robinson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner 10. QUAKE 10501 5 C Baltimore If Under 24 Hrs. 5. Social Security Number (In vrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1**X** M 2 □ F Months Hours Yrs Director 247-44-6236 80 March17,1928SouthCarolina Usual Residence of Decedent the Maryland ral", or items 23a or 28a-f show Examiner must be coffled at 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 30 Teni Court 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No à Specify: Black **X**☐ Widowed 4 ☐ Divorced "natural", Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ဂ္ဂ Otis Robinson Clara Ferguson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29730 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau 704Blake Street, Rock Hill, South Carolina Marion Robinson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MT.ZionAMEChurchCem.4-26-08 Landsford,SouthCar. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. A. 6009Harford Road, Baltimore, Maryland21214 Mar Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician haui /Medical Due to (or as a consequence of) Examiner Onic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed RUMONIA and Due to (or as a consequence of) physician a the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 100 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate has al director, page 2 autopsy rmed? 2 2000 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA s after deam.
al Director: After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintened state and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar 29b. Signature and title of certifier

DR Michael

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pipkin

2008

DHMH 17 Rev 1/2001

9000 Franklin

32. Registrar's Stonature

29c. License number

D5442

29d. Date signed (Month. Day, Year,

SQUASE DrivE BOLLIMOSE, MD &1937

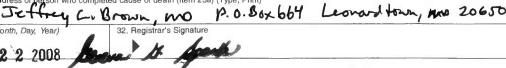
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month Physician 19, April 2008 5:40_a[™].m Marilyn Cecilia Ridgell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 37657 Asher Road St. Mary's Mechanicsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Director 565-26-0083 82 01/01/1926 California Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M. dl. al Examiner must be notified at 1 ☐ Yes 2 X No Director St. Mary's Mechanicsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 37657 Asher Road 20659 United States Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No White Specify: Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Joseph H. Davis Margaret Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory T. Ridgell / Husband 37657 Asher Road, Mechanicsville, Maryland 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr. 4-23-2008 | Charlotte Hall, MD 21 of Funeral Service Security Countries Countries of Funeral Service Security Countries of Funeral 22. Name end Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronery Arter Discuse Physician years /Medical Due to (or as a consequence of): **Examiner** years Disheres Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2: autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 To the To the within 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



dress of person who completed cause of death (Item 23a) (Type, Print)

D42597

	1	For State Registrar Decedent's Name (First, Middle	(act)		Ce	rtificate	e of L	Death	2. Date of Dea	Reg. No.	UUE	3. Time of Death
icia	n	Lucille Virg		r					Month APRIL	Day .	2008	12:43 PN
dica nine		a. Facility Name (If not institution	n, give street and number	r)			Town, or	Location of Dea		4c. Cour	nty of Death	E S
ai or	5	5. Social Security Number 577~16–9389	6. Sex 1 □ M 2 ☑ F	Age (In yrs. las	t birthday, Yrs.	Months	1 Year Days	If Under 24 Hi Hours Mil		, Year) 1,1920	9. Birth Cou Distr	place (State or Foreig ntry) ict of Colum!
	.	Usual Residence of Decedent 10a. State 10b. County Maryland St.	Mary's	10c. City, *	Town or L	ocation	но1	lywood				10d. Inside City Limits
	lrect	Oe. Street and Number	nary 3			10f. Zip		Tywood		10g. Citizen o	of What Cou	intry?
!	ョ	24903 Maverick	Court				2063	36			USA	
	by Fur	Marital Status □ Never Married 2□ Marr ③払Widowed 4□ Divorced	I If Yes, Give	s? 🕽 No	13.	Was Deced If Yes, spec 1 ☐ Yes 2	ify Cuba	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	В	lace - Ameri lack, White cify: Whi	, etc.
	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-40	or 5+)	(Give		k done o e retired	luring most of w)		16b. Kind of		dustry Government
		1.7. Father's Name (<i>First, Middle,</i>	I aet)		Assis	tant Dis	spers	ing Offic	er ame (First, Middle,			
1	ň	Edward L. Cle							cv V. Cre			
1	2	19a. Informant's Name/Relations			19b. Mail	ling Address	(Street &		Rural Route Numbe		vn, State, Zi	p Code)
		Patricia Richar	rds/ Daughte	er	1020	0 Ango	ora I	Drive	Cheltenh			
		20a. Method of Disposition 1X Burial 2 □Cremation 4 □Donation 5 □Other (S	Specify)	cen	netery, cre	osition (Name ematory or of Nation Cemete	<i>ther plac</i> 1a1	e) May	Date 7 2, 2008	20c. Locatio Suit1	n - City or T and,Ma	
		21. Signature of Funeral Service	A Jardes	ner	1.50	P.O. B	ngley Box 2	-Gardiner 70 Leon	Funeral Ho	20650		
		23a. Part1/Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a	sed the death. In line. as conseque		Show the mode	e of dyin	g, such as card	iac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Eather Underlying Cause (Disease or injury	bDue to (or a	as a conseque	nce of):							
ı	Exa	that initiated events resulting in death) Last	c. Due to (or a	as a conseque	ence of):							
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal d t at time of dea	teath 3	□Ectopic pr		,			Date of deli	very Day Year
l.	ן הַ	Part II. Other significant condition	ons contributing to death	but not result	ing in the	underlying ca	ause give	on in Part I.	23e. Did to	/	,	the cause of death?
	Completed	Cerebrova	soulor	Buz	cleu				24a. Was autop perfo 1□ Yes	an 24	prior to c death?	topsy findings availal ompletion of cause of
1		25. Was case ferre to medica examiner	Literature A				Lou		Death (Check only o	ne)		
	2	1 ☐ Yes 2 ☐ No 27. Munny r of Death	Hospital: 1 Inpa		R/Outpation 28b. Time			4 🗀 Nursini	Home 5 ☐ Resident			cify)
1	Certification:	1 Matural 5 ☐ Pendir 2 ☐ Accident investi	ng (Month, i gation	Day Year)	Injury	M Z	8c. Injur Worl 1 □	yai k? Yes 2 □ No	200. Describe	.on injury oci	Jantou	
	<u> </u>	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place of	injury - At hom etc. (Specify)	ne, farm, s	treet, factory	, office		28f. Location (S City or Tox	Street and Nu	ımber or Ru	ral Route Number,

DHMH 17 Rev 1/2001

State Registrar SONG C. CHON, M.D. 7C POST OFFICE RD. WALDORF, MD 20602

31. Date filed (Month, Day, Year)

APR 2 5 2008

Source of death (Item 25a) (1996, 1986)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

APR 1 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		State of Ma	iryland	•	rtmeni tificate			ivier		gierie Reg. No.	17 [] [] (7	14201
	Physicia		1. Decedent's Name	e (First, Middle, La	ast)							Date of De Month	ath Day	2008 ^{Year}	3. Time of Death
	/Medic			ice Smit								pril		County of Deat	11:42 ^{aм}
	Examin	er			ve street and number)					cocation of Dea				Prince G	
-	Funeral		5. Social Security N	nd Avenu		(In yrs. las	st birthday)	If Under	1 Year	If Under 24 Hi		Date of Bir			hplace (State or Foreign
	Director		225-50-4	486	1□M 2፟BF	103	Yrs.	Months	Days	Hours Mi	n. 5	Date of Bir (Month, Da /23/1	904	Albe	marle, VA
Т	pu »		Usual Residence of 10a. State	Decedent 10b. County		10c City	Town or Loc	ration							10d. Inside City Limits
	faryla shov	'n			Campala	roo. Oity,	TOWN OF EOU		Uwat	tsvill	0				1 XYes 2 ☐ No
	the N	rect	MD 10e. Street and Nur		George's			10f. Zip		LSVIII		1	10g. Cit	izen of What Co	untry?
	3a or	Funeral Director		nd Avenu	e. # 505				2	20781				U.S.A	
	death	ner	11. Marital Status		12. Was Decedent B	Ever in U.S.	13. V	Vas Deced	ent of His	spanic Origin? n, Mexican, Pu	(Specify	Yes or No)-	14. Race - Ame Black, White	
2-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	þ	1 ☑ Never Marri 3 ☐ Widowed	ied 2□ Married 4□ Divorced	1 Tyes 2 X N If Yes, Give Year or Dates:	lo		Yes 2						Specify:	hite
5	72 hou	Completed	(Sna	15. Decedent's E	Education		16a. Deced	dent's Usua	l Occupa	tion uring most of w	vorkina		16b. K	ind of Business/	Industry
7	within 7 jiene.	nple	Elementary/Seco		College (1-4or 5	+)	life. L	OO NOT us	e retired)	g			D,	rivate H	lomes
7	e filed within al Hygiene. I other than * vent, I're Me		17. Father's Name	(Eiret Middle Las	· · · · · · · · · · · · · · · · · · ·			Na	anny	18. Mother's N	lame (Fi	irst. Middle			iomes
ana	ld be fi lental F ked ot Ic ever	Be		W. Smith								. (U1			
5	2 should be and Mental is marked craumatic even	은	19a. Informant's N				19b. Mailir	ng Address	(Street a					or Town, State, 2	Zip Code)
Z	and 2 stealth ar m 27 is			•	urn, Friend	ı l	6372	Guilf	ford	Rd., C	1ark	svil	Le, N	MD 21029)
ē,	s 1 ar of Hea item	1	20a. Method of Dis	position			ce of Dispo				Date			ocation - City or	
Ē	Page nent c int: If iry or			☐ Cremation 3 5 ☐ Other (Spec	☐ Removal from State cify)					Cem.4/	23/2	2008	Aft	ton, VA	
galtimor	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Fu	uneral Service Lice	ensee A A A	1	11 22	. Name an	d Addres	s of Facilify					more Ave.
ם	90 E # 9		Per	nest	The Col	UM	, G a	sch's	Fun	eral H	ome,	P.A.	. Нуа	attsvill	.e, MD 20781
					mplications that caused y one cause on each lir						liac or re	espiratory	arrest,		Approximate Interval Between Onset and Death
-	Physician		Immediate Cause disease or condition resulting in death)	on	a. Advance			er's I)isea	ase					6 years
	/Medical Examiner		Todaking in dodain	•	Due to (or as	a conseque	ence of):								
		-	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	onditions, nmediate	b Due to (or as	a conseque	ence of):								
	d ansit	Examiner	Cause (Disease or that initiated events	enlying r injury											
Š	ificate be executed g physician and is the burial-transit		resulting in death)	Last	Due to (or as	a conseque	ence of):								
98/90	ate b	edical			d										
_	- O K		IF FEMALE:		23c. If yes, outcome	of pregnan	cv		327					23d. Date of de	livory
XOR	death certifi e attending d for use as	Physician/M	23b. Was deceder in the past 12	2 months?	1 Live birth 4 Pregnant a	2 Fetal o	death 3	Ectopic p						Month Month	Day Year
o.	0 0	ysi	1 ☐ Yes 2: 9 ☐ Unknowr		9 Unknown										
٠ <u>٠</u>	The law requires that the ate has been signed by thoage 2 should be detache	by Pt	Part II. Other signi	ificant conditions	contributing to death b	ut not result	ting in the u	nderlying c	ause give	en in Part I.		23e. Did	tobacco	use contribute t	o the cause of death?
ğ	equire en sig										-	1 🗆	Yes 2	. Mo 3 □ P	robably 4 Unknown
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<u> </u>		lig.										perl 1 □ Yes	ormed? 2 🛣 N	death? o 1 ☐ Ye	s 2 🗆 No
/ita	ysician: is certific director,	Be	25. Was case refe examiner?	rred to medical	Hospital:				Othe	26. Place of I					
0	Physical direction	은	1 ☐ Yes 2 🔀		Hospital: 1 Inpatie	ent 2 E	R/Outpatie		JA	4 LI NUISKI	-			6 ☐Other (Spe	ecify)
0	ding F h. After funera	tion	1 X Natural 2 ☐ Accident	5 Pending investigat	(Month, Da	iy, Year)	Injury	м	28c. Injury Work 1 □ \	?° Yes 2 □ No				.,	
Division	Attending Physician: if death. ector: After this certific by the funeral director,	Certification: To	3 🗌 Suicide	6 Could not	be Ose Blood of Ini	ury - At hon	ne, farm, sti	eet, factory	y, office		28f	Location City or To	(Street a	ind Number or Fi	ural Route Number,
á	ppital or ours afte leral Dire	Sert	4 Homicide		building, et	c. (Specify)	,					Oily of 10	own, orac		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	1 X Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examinati	vledge, deat ion and/or ir	th occurred rvestigation	at the tin	ne, date and p pinion, death c	lace, and occurred	d due to th at the time	e cause(e, date ar	s) and manner and place, and du	as stated. e to the cause(s)
	To the Hosi within 24 ho To the Fund completely i	Me	29b. Signature and					290	c. License	e number			29d. D	ate signed (Mon	th, Day, Year)
È			1	hh	a Jeh	1/2	/			D22309			Apr	il 12,	2008
1)	(9)		30. Name and add	Iress erson wh	no completed cause of										
1-	- (d)		Phillip 31. Date filed (Mo	W. Poth	8712 M	aywoo	d Ave	., Si	lver	Spring	, M	D 209	10		
	Sta Regist		APR	0.000	Se con legisti	rar's Signatu	foods								

DHMH 17 Rev 1/2001

08-02761								
Jeffery Stribling								

THERY STRIBLING	1	State of Maryland / Department of For State	of Death	ygierie Reg. No	200	8 1420
Physicia	n/	- For State legistrar Ameno#19a 20a ~20c PerFam P004-16-06cate of 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day		3. Time of Death
ledical Examii	ner	Jeffrey Stribling		April 8, 2008		1035 hrs
		ta. Facility Name (if not institution, give street and number) 4200 Kaywood Drive Apt. 3	4b. City, Town, or Location of Death Mount Rainier		4c. County of Death Prince George	's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth (Mi	M/DD/YYYY) 9. Bir	hplace (State or Foreign
Director			Months Days Hours Min	1/13/19		untry) mingham,AL
		Usual Residence of Decedent				10d. Inside City Limits
ow any	- 1	10a. State 10b. County 10c. City, Town or Loc				1 X Yes 2 No
Aaryland 28a-f show 1 at once.	횽	Maryland Prince George's Mount Rai	ner 10f. Zip Code	10g. C	Citizen of What Cour	ntry?
he Mar 1 or 28 iffed a	Director	4200 Kaywood Drive # 3	20712	Uni	ted State	s
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	can Indian, Black,
or ites	Funeral	Never married 2 married 1 Yes 2 No		7110011, 0101,	Specify: Bla	ok
rs afte ural", miner	<u>ā</u>	or Dates:	Yes 2x No specify: ent's Usual Occupation (Give kind of	work done 16b	. Kind of Business/	
72 hou n "nat al Exa	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use ret	ired)		
vithin ene er that	ompleted		e Officer Retired		.C. Gover	nment
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	0	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide		
212 uld be Menta mark	To Be	Evan Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or	eorge Fost Rural Route Number,	City or Town, State	e, Zip Code)
MD d 2 sho lith and n 27 is aumati		Kimberly Stribling-Daughter Daryl Fox / Brother 1816	17th Street S.E.	Washingto	n, D.C. 2	20020
ore, ss land of Heal If iten		20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 X Cremation 3 Removal from State	osition (Name of cemetery, other place) tan Crematory	1	lexandria	·
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Mary Land	-Veterans 4/1	7/2008 I S	heltenham	Md.
Bal permit Depar Impor		7	2. Name and Address of Facility ope 5538 Marlboro Pike			
Physician		23a. Part I. Enjer the disease, or complications that caused the death. Do not ente	er the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
'Medical .xaminer		failure. Ast only one cause on each line. Immediate Cause (Final disease a. Chronic Alcoholism				Death
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or condition resulting in death) Due to (or as a consequence of):				
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Useasee or injury that initiated events resulting in death) Last Due to (or as a consequence of):				-
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Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED				
8760, ificate bug physicals the bun	M/I	IF FEMALE: 23b. Was decedent pregnant in the 2 Live birth 2	Fetal death 3 Ectopic pregr		23d. Date of deliver Month	ry Day Year
Box 6876 The death certificate the attending physele for use as the	sicia	past 12 months?	Other (Specify)			
. Bo the dea y the a	Physician/	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
cords, P.O. aw requires that the has been signed by should be detach	Š			1 Yes 2	2 No 3 Pro	obably 4 🗸 Unknown
of Vital Records, ng Physician: The law require After this certificate has been si nneral director, page 2 should b	Completed			24a. Was an autopsy		utopsy findings available completion of cause of
Recol The law icate has	dmc			performed		
tal Rectian: The certificate	Be C	25. Was case referred to medical	26.Place of Death (Chec			
· Vit. Physici r this c	To E	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpati		28d. Describe how	sidence 6 🗸 Oth	er: Scene
ion of tending Pheath.		27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	1 Yes 2 No	200. Describe now	injury occurred	
Division tal or Attendii rs after death. al Director: A	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.			tural Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifitely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, State	e)	
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death or one) Medical Examiner: On the basis of examination and/or invest	courred at the time, date and place, ar	nd due to the cause(s) and manner as sta	ated.
To the Hos within 24 h To the Fur completely	Medical	2 Medical Examiner: On the basis of examination and/or invest and manner stated. 29b. Signature and title of certifier	29c. License number		9d. Date signed (M	
	2	200. Spinding and the State of	O.C.M.E.	1	April 9, 2008	
(X)		30. Name and address of person who compared cause of death (Item 23a)				
0	Į Į	Laron Locke MD. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 21	201		
S Regis		31. Date filed (Month, Day, Year) APR 1 6 2008 32. Registrar's Signature)			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

with the Maryland Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)

Baltimo	permit. Pages Department of Important: If i any Injury or once.
	Physician /Medical

ed by the attending physician and detached for use as the burial-transit death certificate be executed Division or Vital Records, P.O. Box 68760, this

Physician 12:25pm^M April 2008 Raymond N. Simons /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 6605 Lacona Street District Heights If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral 1** M 2 □ F 9/11/1935 72 Durham, NC Director 577-44-3354 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XXYes 2 □ No Director Maryland | Prince George's District Heights 10e. Street and Number 10g. Citizen of What Country? 6605 Lacona Street 20747 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. i. 1 and 2 should be filed within 72 hours after Heafth and Mental Hyglene. Heath and Martal Hyglene. The Transural", or ite em 27 is marked other than "natural", or ite other traumatic event, the Medical Examine. 1 □ Never Married 2 X Married 1 ☐ Yes 2 ▼ No Black Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brick Layer Foreman Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Doris Edna Simons Norman Simons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6605 Lacona Street District Heights, Md. 20747 Joyce Simons/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/14/2008 Brentwood, Maryland Lincoln Memorial 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service Lice see Rung MOLUST 5538 Marlboro Pike Forestville, Maryland 20747 Pa 11. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final a LUNG CANCER resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ★ Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes <u>3</u>₽ No 1∐ Yes 2 🙀 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 ☐ DOA P s after death. 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mi April 8, 2008 MD21528 4 e and address of person who completed cause of death (Item 23a) (Type, Print) Anderson 3800 Reservoir Road NW Washington, D.C. 20007 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** 6 Norma B. Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctors Hospital Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 XXF Director 62 5/24/1945 Wash. D.C. 219-46-5619 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1√TYes 2 No Directo <u>Maryland Prince George's</u> District Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7110 Foster Street 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Not $p \ell \ell \ell$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell A. Davage Berlyn Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9343 Birch Cliff Drive Fredericksburg, Va. 22407 Thomas P. Smith/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 4/12/2008 Clinton, Maryland 21. Signature of Funeral Service Light 22. Name and Address of Facility Pope Funeral Homes, P.A. 23a. Part 1. Enter the disease shock, or heart failure. or of ass 5538 Marlboro Pike Forestville, Maryland 20747 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown natributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury

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D	To the Hospital of within 24 hours at To the Funeral Completely filled it	O to the line
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29b. Signature and title of certifier

and manner stated.

6 Could not be determined

² 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Good Luck Rd. Lanham, Md.

Medical

2 Accident

3 ☐ Suicide

29a. Certifier (Check only

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Reg. No. 4 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month APRIL 2008 REGINA SMITH SCOTT 9:57 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGE'S HYATTSVILLE HCR MANOR CARE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday Days Hours Year Months 1 □ M 2 🛛 F VIRGÍNIA 95 March 13, 1913 255-36-5250 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No PRINCE GEORGE'S NEW CARROLLTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20784 5540 Karen Elaine Drive #1642 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. I □ Yes 2 X No f Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katie Wallace Woodson Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5540 Karen Elaine Drive #1642 New Carrollton, MD 20784 Florine Scott / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Smith Family Cemetery 04-08-2008 Schuyler, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thacker Brothers Funeral Home 21. Signature of Funeral Service Licenses 24590 Scottsville, VA 650 Valley Street, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) YDC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last STAGE Due to (or as a consequence of). 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Year Month Day ☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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12 should be filed whand Mental Hygier is marked other the

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic

the Medical

or other traumatic event,

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Division or Vital Records,

Director

Funeral

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Completed

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MD

Examine Physician/Medical IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1□ Yes 2 X No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 ER/Outpatient 3□ DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Iniury 1 □ Yes 2 □ No

28d. Describe how injury occurred

24a. Was an

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier MO

5 ☐ Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREENBERT MARILAND 2017 ANOVER

1 ី🇴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7011ie Smith April 2008 2148 P. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days Months 1⊠M 2□F 92 237-52-3985 September 12, 1915 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at Capital Heights Prince George's Maryland 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be a once. 20743 U.S.A. 517 Clovis Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlott Jenkins Minger Smith ဂ္ 19a. Informant's Name/Relationship (Type. Print)
Mr. Ivan R. Smith (Son) 19b. Mailing Address (Street and Number of Ryral Route Number, City or Town, State, Zip Code) 517 Clovis Avenue Capital Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State April 19, 2008 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) 4 months **Physician** Cardiac Antivitaria /Medical Due to (or as a consequence of) **Examiner** 1 year Coronary Artery Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the nse 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death I□Yes 2□No 9☐Unknown detached 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Respiratory Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an certificate has page 2 : 1 | Yes 2 🔽 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**₹** No 2 ER/Outpatient 3 DOA 1 Yes 1X Inpatient this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Injury 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No e Hospital or Attendl 124 hours after death. e Funeral Director: A death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D16273MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6130 Landover Road Cheverly, Maryland 20785 Revathy Murthy, M.D. 31. Date filed (Month, Day, Year)

APR 1 & 2008 32. Registrar's Sign

DHMH 17 Rev 1/2001

State

Registrar

APR 16

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Agency Services of	792 s M. Starcl		Please Type or Print in Black Indelible I State of Maryland / Department of Cortificate of Corti	of Health and Mental Hy	/giene	200	18 142		
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23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of syring, such as cardiac or respiratory arrest, shock, or heart flature. List only one cause on each time. Immediate Cause (final disease or condition resulting in death) Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death Deat	permit. Pages Department of Important: If injury or othe		4 Donation 5 Other Specify: MD Vetera 21. Signature of Funeral Service Licensee 22.	n's Cemetery 4/1 Name and Address of Facility	Beall Fun	eral Home	n, MD		
AMENDED AME	Medical aminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		r respiratory arrest	, shock, or heart	Approximate Interve Between Onset and Death		
Cardiomegaly 1	an a	nysician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fegnant at time of death 5 (ancy				
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	law requires that the has been signed by e 2 should be detache	by		e underlying cause given in Part I.	1 Yes 24a. Was an autopsy perform	2 No 3 Prol 24b. Were au prior to death?	topsy findings available completion of cause of		
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ysician: The nis certificate director, pag	Be	examiner? Hospital: Inschipate 2 of ED/Outpation	Other	only one)				
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ttending Phydeath. tor: After thy the funeral	_	27. Manner of Death 1 Natural 5 Pending POUND: 28a. Date of Injury FOUND: 4 Accident Investigation Apr 9, 2008 28b. Time of FOUND: 4 FOUND: 4 Page 18 Page	1 Yes 2 ✔ No	Subject drow	ned			
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Hospital or A 24 hours after Funeral Direc ely filled in by		3 Suicide 6 Could not be determined (Specify) River 29a. Certificing Physician: To the best of my knowledge, death occ	curred at the time, date and place, and	or Town, Sta 17500 blk. Gove due to the cause(te) ernors Bridge Road s) and manner as stat	d , Bowie , Md		
Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	To the l within 2 To the l complete	Medica	one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	ation, in my opinion, death occurred a	at the time, date an	od place, and due to the 29d. Date signed (Mo	e cause(s)		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar APR 1:7 2008	41		Melissa Brassell, MD Assistant Medical Examiner 111	Penn Street, Baltimore, MD	21201				
17 Rev 1/2001 ORIGINAL	Regis	trar	APR 1 7 2008	<u>, </u>					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:45 aM 2008 **April** 13 Annunziata Innocenti Saulsbury /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Olney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 K F 90 December 24,1917 Pennsylvania Director 577-12-6443 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Montgomery 01ney 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 should be filed within 72 hours after death with an and Mental Hygiene.

is marked other than "natural", or items 23a or: 17053 Old Baltimore Road 20832 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Innocenti Anna Orsi မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun <u>once</u>. Mary Louise Daneri - Daughter 7913 Brightmeadow Court, Ellicott City, Maryland 21043 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 04/18/2008 Silver Spring, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Immediate Cause (Final Physician Bilateral Pleural Effusions DAYS arge disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Decompensated Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑No ed by the detached 9 Unknown 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 1 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 The Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) vithin 2 and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ 1+0065661 2008 لم 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip Drive 20832 Deborah Stein, DO 18101 Olney, MD 31. Date filed (Month, Day, Year) APR 16 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 1:00 P M 4 2008 14 Witold Victor Stankiewicz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12 • 12 • 1906 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□F Poland 101 Director 216-32-3585 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r then "naturel", or iteme 23a or 28a-f ehow Ite Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA e filed within 72 hours after death 1 at Hygiene. other then "nature!", or iteme 23s 9074 Old Ocean City Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0wner Barber 8 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny linjury or other treumatic event once. 17. Father's Name (First, Middle, Last) Be Helen Zajul Bolestaw Stankiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9074 Old Ocean City Road, Berlin, Maryland 21811 Katherine Kolarik 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crem. 4.15.2008 Frankford, DE 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William Street, Berlin, Maryland colo 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Abdourthat **Physician** Anewysm Aux tou disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) DOB: I 1 ☐ Yes 2 ☐ No ivision of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed peeu ; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 🕱 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 3□ DOA Certification: To tankiewicz, 16-32-3585 within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending 1 Natural 2 Accident 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitai 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08 D48130 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Healthoug Drive Berlin, Md 3A 3 Tettsey Thomas Greenwood 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 5, 2:36am April Stewart Aaron Tate /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Months 1 TX M 2 □ F 2/18/1961 Washington, D.C. Director 579-92-9489 47 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show be notified at 10a. State 10b. County 1 X Yes 2 ☐ No Director DC Washington 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States r than "natural" or items 23a the Medical Examiner must b 20001 47 53rd Street S.E. Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏝 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 N Married Specify: Black Baltimore, Maryland 21215-0036 1 ∐ Yes 2K No If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 House Keeping Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil trent of Health and Mental Hant: If item 27 is marked ott Jury or other traumatic even Be Leola Mae Bruce James E. Tate Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 47 53rd Street S.E. Washington, D.C. 20001 Department of Health Important: If item 27 any injury or other tr Karen Michele Tate/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 4/15/2008 | Alexandria, Va. 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lionsee 0101005 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due Examiner Sequentially list conditions, if any, budget to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached i ☐Yes 2☐No 9 Unknown 9 🗌 Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has le 2 autopsy performed? /es 2 No page certificate 1___ 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Box 68760. o ۵. or Vital Records, Division

> State Registrar

31. Date filed (Month, Day, Year) APR 1 1 2008

Ansari

(Check only one)

29b. Signature and title

7E 1051 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO057219

29d. Date signed (Month, Day, Year)

fice Road, WALDORF, MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Physician 2008 APRIL DAN THOMPSON 13 00:38 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1 M 2 □ F 65 245-64-0645 Director 01/01/1943 LUMBERTON. NC. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expressional be maithed at 1 X Yes 2 □ No MD PRINCE GEORGES HYATTSVILLE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20781 5703 43rd AVENUE # 3 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 TNo Specify: 2 Specify: BLACK 3 Widowed 4 Divorced Year or Dates: ARMY Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CHEF PRIVATE 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILDRED MITCHELL LEE THOMPSON ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3322 DEERING DRIVE RALEIGH, NORTH CAROLINA 27616 19a. Informant's Name/Relationship (Type. Print) DAVID PAGE/SON 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o KNIGHTDALE, NORTH CAROLINA 1 ☐ Burial 25 ☐ Cremation 3 ☐ Removal from State H.L. POOLE CREMATORY 4/18/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME ROAD LANDOVER, MARYLAND 20785 7474 LANDOVER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** www disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to instruct data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: asn yes, outcome of pregnancy

Live birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy perform 1 ☐ Yes 2 🖺 No 1 □ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Inpatient After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatule

State Registrar 30. Name and

31. Date filed (Month, Day, Year) 801 **APR 1 6**

dress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year CATHERLINE THOMAS

7. Age (In yrs. last birthday,

48

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

SUITLAND

Days

2008

PRINCE GEORGES

9. Birthplace (State or Foreign Country)
N. Carolina

10d. Inside City Limits

Year

4c. County of Death

4:45A

10

APRIL

8. Date of Birth (Month, Day, Year) 07-30-1959

Physician /Medical Examiner **Funeral** Director

4a. Facility Name (If not institution, give street and number)

1 □ M 2 3 F

6308 DAVIS BLVD.

5. Social Security Number

217-70-2361

Usual Residence of Decedent

r 28a-f show notified at o e filed within 72 hours after death with Hygiene. ns 23a c must b "natural", or items edical Examiner n other than "natu vent, the Medical 12 should be fill h and Mental H 7 is marked oth

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

27 item 2

physician and s the burial-trans as 1 attending use for signed by the a page 2 certificate director After this funeral

requires that the death certificate be executed

Box 68760.

P.0.

Division or Vital Records,

Hospital or Attending P I hours after death.

uneral Director: After t filled in by within 24 hours a

To the Funeral C Medica State Registrar

10c. City, Town or Location 10a. State 10b. County 1. Yes 2 □ No Director Maryland Prince Georges Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6308 Davis Blvd. 20746 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Ž ☐ No Specify: þ Black 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Uniform sales College (1-4or 5+) Cleaner-Hanger 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hubert Murry Clara Mae Davis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7205 G Street, Seat Pleasant, MD 20743 19a. Informant's Name/Relationship (Type. Print)
April A. Walls/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any Injury or oth Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem.: 04-18-08 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Sign ture of Funeral Servi / Liven les 6500 Allentown Rd., Camp Springs, MD20748 tt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Unerly g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? 28 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home S Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature apartitle of 6 death (Item 23a) (Type, Print) er person who comp 30. Name and addre cause o NADA MD

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

APR 1

2008

32. Registrar's Signat

For

			- State Registrar			Cei	rtificate of i	Death	7		Reg. N	<u>.</u> _ 0 0 0	1 '7	
1	DI		1. Decedent's Name (First, Middl	e, Last)						2. Date of De Month		ov Vone	3. Time of	Death
h	Physici /Medic		Roland E. Thom	as, Jr.						April		2008 Year	12:40	A^{M}
	Examir		4a. Facility Name (If not institution)		4b. City, Town, or	Location	of Death			c. County of Dea		
			Larkin Chase Nu	rsing Home			Bowie				1	Prince G	eorge's	
- half-su-	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Bir	thplace (State o	
	Director		577-28-8142	1 ½ M 2□F	83	Yrs.	I Worth Days	riours	IVIII.	Oct. 5	, 19	24 Was	hington	D.C.
	pu ,		Usual Residence of Decedent		10c City	Town on Lo							Trans.	
	aryla shov d at	_	10a. State 10b. County		Toc. City,	Town or Lo	cation						10d. Inside Ci	
	8a-f	ctc		Arundel	Seve	erna P	ark						1 1 163	22 110
	or 2	Director	10e. Street and Number				10f. Zip Code				10g. C	itizen of What C	ountry?	
	ath v	2	428 Severnsid				21146				US			
	tems	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	3. 13.	Was Decedent of H If Yes, specify Cuba	ispanic O an, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whi		
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Vac Give	No		1 ☐ Yes 2X No	Specify	<i>/</i> :			^{Specify} ₩hi	to	
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7	e filed al Hygi other vent, tl		17. Father's Name (First, Middle,	Last)		- 110	302002 11			(First, Middle				
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2	2 should be and Menta is marked aumatic ev	ပ္	19a. Informant's Name/Relations		i	10h Mailie	ng Address (Street						Zin Codo)	
<u>8</u>	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		Melissa J. Sh					_						
a,	s 1 and 3 f Health Item 27 other tr		20a. Method of Disposition	legogue	20b. Pla		Severnsi			Severna Date		ocation - City or	21146	
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g	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service	Licensee			2. Name and Addres					cal Home e, MD 2	0175	
			On Part Established Source									2, MD Z		
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each	ine.	Do not ent			s cardiac c	ir respiratory a	rrest,		Approximat Interval Bet Onset and	ween
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0	death c e attenc ed for us	=	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 ☐ Fetal o	death 3□	Ectopic pregnancy				Ī	23d. Date of de Month		rear .
	ne de the a	hysicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of dea	ath 5∟	Other (specify)						24)	
7	w requires that the death been signed by the atter should be detached for u	Ph)	Part II. Other significant condition	ane contributing to death	but not result	ting in the ur	adarhvina aayee aive	on in Bod		220 Did t	ahaaaa	use contribute to	a the sauce of a	looth?
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<u> </u>	The aate he	5								perfo	rmed2	- death?		
VII	ctor,	Be (25. Was case referred to medical examiner?					26. Plac	e of Death	(Check only o				
	hysic his c	5	1 Yes 2 100	Hospital: 1 Inpati	ient 2 ☐ E	R/Outpatien	t 3 DOA Othe	er: 441 N	lursing Hor	ne 5□Resi	dence	6 □Other (Spe	ecify)	
0	ng P fter t		27. Manner of Death ↑ Natural 5 Pendin	28a. Date of Inj (Month, Da		28b. Time of Injury	28c. Injur Worl	y at </td <td>2</td> <td>28d. Describe</td> <td>how inju</td> <td>ary occurred</td> <td></td> <td></td>	2	28d. Describe	how inju	ary occurred		
VISION	endi ath. or: A he fu	atic	2 ☐ Accident investig	ation				Yes 2□]No					
<u>"</u>	er de rect	tific	3 ☐ Suicide 6 ☐ Could in determ	ined Zoe. Place of III	jury - At hom	ne, farm, str	eet, factory, office		2	28f. Location (S City or To	Street a	nd Number or R	ural Route Num	ber,
	tal o	Certification:										,		
	hour hour		29a. Certifier	Time Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	One/	and manner s	tated.	G.1G.OI III			-aui occuli	odat tile tillle,	जवास वा	is piace, allu du	o to trie cause(s	·)
	with To t	Σ	29b. Signature and title of certifie				29c. License	e number			29d. Da	ate signed (Mon.	th, Day, Year)	
			· CAT				D	570	28		00	4-16-0	8	
,	X)4;		30. Name and address of person	who completed cause of	death (Item 2	23a) (Type,		*	_					
_	01		Aditya Chopra		- 1711	doct.	v Aven	ve:	# 23	An	nou	polls v	ND ZI	401
	Sta		31. Date filed (Month, Day, Year)	a 32. Regist	rar's Signatu	120	1					1		

DHMH 17 Rev 1/2001

Registrar

APR 1 7 2008

		1	1 - For State Registrar	State of Marylar		artment of H		d Menta	al Hygier	Em Q U L	1 2 1
×	STY Sy.	*	1. Decedent's Name (First, Middle, Last,						te of Death	Day Year	3. Time of Death
	Physici /Medic		Carolyn Lee Taylor	<u> </u>					ril 20		11:13PM [™]
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or				4c. County of Deal	
			38588 Laurel Ridge 5. Social Security Number 6. Sec		last hirthday)	Mechan			te of Birth	St. Mary	7 'S hplace (State or Foreign
4	Funeral Director			M 2♥F 52	Yrs.	Months Days		Min. (Mo	onth, Day, Yea	ar) Co	uth Carolina
	91		Usual Residence of Decedent							,	
	ehow	5	10a. State 10b. County Maryland ST. Ma		ity, Town or Lo M e	cation chanicsv	i11e				10d. Inside City Limits 1 ☐ Yes 2 X No
	28a-1	Director	10e. Street and Number			10f. Zip Code			100	Citizen of What Co	
	with Sa or		38588 Laurel Ric	loe Drive		206	59		109.	U.S.A.	ond y
	ms 23	Funerai		12. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba		? (Specify Ye	es or No-	14. Race - Ame	
ထ	or ite	교	1 ☐ Never Married 2 💢 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		t Yes, specity Cuba 1 ☐ Yes 2 No		uerto Hican,	etc.)	Black, Whit	
	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						Specify: Wh	
5	n 72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	working	16b	. Kind of Business	Industry
12	iene iene r then	mo du	Elementary/Secondary (0-12)	College (1-4or 5+)		lanager	,			Oil Compa	any
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural', or items 23a or 28a-1 show appring or other traumatic event. I'm Madical Examinat must be notified at once.	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First,	Middle, Maid	len Sumame)	
/lar	Menta	TOE	Røbert C. Butler				Minni	ie Lee	Lyons		
lan	2 sho and is mu		19a. Informant's Name/Relationship (Ty			ng Address (Street				-	
න න	1 and lealth im 27 ther tu	1 1	Donald J. Taylor, 20a. Method of Disposition		_					Location - City or	, MD 20659
altimore,	ages nt of h :: If its		1√2 Burial 2 ☐ Cremation 3 ☐ F	terrioval from State		sition (Name of natory or other plac	1 -	-24 ^{Date} 8		ldorf, Ma	
ᄪ	artmer artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligens		-	lemorial (
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	\$ x 1		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the dea	th. Do not ent					115 11D 20	Approximate Interval Between
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	bed is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):						
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9	tificate ig phys as the	ledic									
Вох	death certific e attending p d for use as	Physician/Med	230. Was decedent pregnant	3c. If yes, outcome of pregn 1☐Live birth 2☐Fet		Ectopic pregnancy				23d. Date of de	•
		sici	in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)				Month	Day Year
О. О	The law requires that the de ite has been signed by the a page 2 should be detached		Part II. Other significant conditions con	atchuting to death but not re	sulting in the u	nderwing cause aw	en in Part I	25	Re Did tobaco	o use contribute to	the cause of death?
ds,	signe d be	d by	, and me of the order	Milesting to dealing at his he	soung in the di	indonying oddao gir	orrarr arci.		1⊠Yes		robably 4 □Unknown
Sor	w require been signature should b	ete						24	la. Was an	24h Were a	utopsy findings available
Ä	The lav	Completed							autopsy performed	? prior to death?	completion of cause of
ī		BeC	25. Was case referred to medical				26 Place of	Death (Chec	Yes 2/K	No 1 Yes	2 12 No
⋛	Physician: rthis certifica ral director, p	ToB	examiner? 1 ☐ Yes 2 Ø No	lospital: 1 Inpatient 2] ER/Outpatier	nt 3 DOA Oth	05	- '-		6 Other (Spe	city)
0	Attending Physician: r death. sctor: After this certific. by the funeral director.		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	y at k?	28d. D	escribe how in	njury occurred	
Sio	ttendi Jeath. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2□No		(0)		
Division of Vital Records,		Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, tarm, str ify)	eet, factory, office			ty or Town, Si		ural Route Number,
_	To the Hospitsl or within 24 hours after To the Funeral Dii completely filled in		29a. Certifier 1 Certifying Phy	sician: To the best of my kn	owledge, death	n occurred at the fin	ne, date and p	place, and du	e to the cause	e(s) and manner a	s stated.
	ne Ho	edicai	(Check only 2 Medical Exami one)	ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death o	occurred at th	ne time, date	and place, and due	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens		2 0	-	Date signed (Mont	
1) Kr			.D OC	5173	28		4/21/	2008
0	500		30. Name and address of person who co	ompleted cause of death (Ite			(1 -	J 0045	16		
	/ V V	· a	Kae T. Aung, M	32. Ragistrar's Sign		lywood, N	larylan	10 2063	Ö		
	Sta Registr			008		hand a					

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ORIGINAL

		For State	State	of Maryla		ertment of F		Mental Hy	2.0	n a	16213
		Registrar 1. Decedent's Name (First, Midd.	le Last)				Dealii	2. Date of Dea	Reg. No. 💪 U	00	3. Time of Death
Physic	cian		. ,	_				Month	Day	Year	
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Funera		Bethesda Hea 5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year	hesda If Under 24 Hr	S. 8. Date of Birt		tgom	olace (State or Foreign
Directo		579-86-2377	1 🕅 2 ☐ F	Trigo (myro	36 Yrs.	Months Days	Hours Mir		y, Year)	Cour	ntry)
		Usual Residence of Decedent	L		30		<u> </u>	May 1	19/	VV	ash.,DC
ylan how	١.	10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
a-f s	Ş	Md.	PG		Temp	le Hill:	S				1X Yes 2 ☐ No
h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
h wit		5717 Camp S	prings A	Avenue		2074	8		United	a st	ates
VICE 13-UUSO I within 72 hours after death with the Maryland yiene, r than "natural", or items 23a or 28a-f show the Modeal Evaminar must be notified at	Funeral	11. Marital Status		cedent Ever in U	J.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Specify Yes or No-	14. Rac	e - Americ	can Indian,
after or it		1 ★Never Married 2 Mar		2 No		☐Yes 2 No	Specify:	irlo Hicari, etc.)		ck, White, e	etc.
2-0030 72 hours aff natural", or	d by	3 ☐ Widowed 4 ☐ Divorced	Year or l	Dates:			эреспу.		Specify	Bla	ack
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Walylallo	100	19a. Informant's Name/Relations						Rural Route Numbe		State, Zip	Code)
		Shirley Fark	as/moth		Temp	ole Hil	Is, MB	Avenue 20748			
Datumore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 ☐ Removal from	State 205.	cemetery, crem	ition (Name of atory or other plac	e) 1/1	Date 18/08	20c. Location -	City or To	wn, State
Dallinofe, bermit. Pages 1 ar Department of Hea important: If item; any injury or other once.		4 □ Donation 5 □ Other (S	pecify)			le Park	Cremat	tory			le, Md.
ermit ermit bepar npor ny in		21. Signature of Funeral Service	Licensee	10.	22	Name and Addres	ss of Facility ${ m H}{ m C}$	odges &	Edward	ls F	.Н.
G G G G		young	- 1700	ge-						ind,	Md.20746
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not ente	er the mode of dyin	g, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	. ACQ	VIRED	IMM	UNUBEFO	ENCY	5 YND	Rome		Onset and Death
/Medical Examiner		resulting in death)		(or as a consec							
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Physician: The law requires that the death certificate be executed rithis certificate has been signed by the attending physician and rial director, page 2 should be detached for use as the burial-transit	dical		d								
eath certific attending p		IF FEMALE:				_				1	
ath cel	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	tcome of pregn birth 2 ☐ Feta	al déath 3 □	Ectopic pregnancy	/		23d. Dat Mo	e of delive	•
the a	sic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Preg 9 ☐ Unki	gnant at time of nown	death 5	Other (specify)			MO	Jun -	Day Year
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ding Physician: The Information of Affer this certificate had funeral director, page	Con							perfor	med? c	leath?	2 MNo
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r Att	tit	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	e of Injury - At h	ome, farm, stre	et, factory, office		28f. Location (S	treet and Number	er or Rura	l Route Number,
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:			g, 0.0. (Opour				City or Tow	i, Siale/		
ospi hour uner ly fill		29a. Certifier 1 Certifyin	g Physician: To the	e best of my kno	owledge, death	occurred at the tim	ne, date and plac	ce, and due to the	ause(s) and ma	nner as s	tated.
he H in 24 he Fi plete	Medical	one)	Examiner: On the band man	nner stated.	auon and/or inv	estigation, in my of	oinion, death occ	curred at the time, o	late and place, a	and due to	the cause(s)
To t To t	Σ	29b. Signature and title of certifier				29c. License	number	2	9d. Date signed		
		lu	en/Som	o m	0	200	7/20	r .	4/16	105	2
		30. Name and address of person	who completed cau	se of death (Iter	n 23a) (Type, P	rint)					
		Truong Bao.	9715 Med	dical o	Center	Dr #2	01 Ba	nless 1 1 -	L P.M) 0 0 5	0
Sta		Truong Bao 31. Date filed (Month, Day, Year)	32. F	Registrar's Signa	ature	D1 . # 6	UI, KO	-rviile,	tild . z	: U & 5 (J
Regist	rar	APR 1 6 2008	Real	K A	man 1						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Weaver-Arighamu 17:05 PM Khonda April ,2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayrota Care Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🗶 F 19,1967Baltimore,MD Yrs. Nov. 40 220-92-1187 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 XYes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 USA 3641 Forrest Hill Road Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Black Specify: 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Priv Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Unknown) Helen Freddie E. Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aunt Vivian L. Weaver-JOhnson 8364 Lincoln Drive, Jessup, MD 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, DC Howard University 4/9/08 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service L 3821 14th Street, NW, Washington, DC 20011 Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) Metastatic Breast Cancer YEARS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Clostridina 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ ☐ Unknown fracture, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

P.O. Box 68760,

Division or Vital Records,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after death

altimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: if item 27 is marked other than "

Department of Health Important: if item 27 any injury or other the once.

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burlal-trar ed by the

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown þ Completed gastroenteriti 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No Certification: To 27. Manner of Death

1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier (Check only one) 5 Pending investigation 6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 □ Yes 2 □ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature/and title of certifie

29c. License number D59562

29d. Date signed (Month, Day, Year) April 8, 2008 Bayrow Con Center 5505 Hylan Bagracha

30, Name nd address person who completed cause of death (Item 23a) (Type, Print)

Shelia Con Zali, Mo Baltonia II

31. Date filed (Month, Day, Year)

32 Registrar's Signature

State APR 16 2008

and manner stated.

To the Hospital < within 24 hours af To the Funeral D

08-02838 Michael Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

200	3	421
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			I-For State Registrar															
	Physicia al Examii	ın/	1. Decedent's Name (First, Middle,Last) er Michael Williams									2	2. Date of Death Month Day Year April 11, 2008 3. Time of Death 1133 hrs					
			4a. Facility Name (if not 1898 Governor		-	number)		4b. City, To Davids	own, or Lo sonville		Death			4c. County of Death Anne Arundel]
	Funeral		5. Social Security Number	er	6. Sex	7. Ag	ge (In yrs. la	st birthday)		If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (S Months Days Hours Min.					lace (State or	٦		
י	Director		218-17-245		1 X M 2	F	22	Y		Days	Hours	IVIITI.	June	24,			WFlorida	4
	any	-	Usual Residence of Deci 10a. State 10b.	County			10c. City,	Town or Loca	ation							10	d. Inside City Limits	- 1
	<u> </u>	5	MD An	ine A	rundel		Cro	fton								1	Yes 2X No	
	Maryli r 28a-f ed at o	Director	10e. Street and Number						10f. Zip						itizen of What Country?			
	ath with the items 23a or ust be notifie		913 Easth	am C			it Ever in U.	S 13 W	/as Deceder	211		n? (Spe	USA ecify Yes or No- 14. Race - American Indian, Black,				n Indian, Black,	\dashv
	death with the Maryland or items 23a or 28a-f sho	Funeral	COMPANIE .	2 Ma		d Forces			Yes, specify						White, etc			
	safter ral", o	by F		or Dates:							Specify: Wh:	_	unto					
	2 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							KING OF BUSINE	:55/IIIu	ustry	ij					
036	ithin 7 me. r than fedica	Completed	- 12 Clerical State								f M	aryland						
15-0	filed w I Hygid d othe													1				
MD 21215-0036	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ro Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town									City or Town, S			┨			
M	id 2 sho lith and m 27 is aumati		Deborah A. Williams/Mother 913 Eastham Ct., Apt.							pt.			ton, M			4		
Baltimore,	es l ar of Hea If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service-bicensee/ 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 4/13, 2008 Alexander Address of Facility 22. Name and Address of Facility Beall Funeral Ho									-						
Itim	it. Pag irtment ortant: ry or o	-											a, vA	4				
Ва	permit. Departm Imports injury o		Many Redde 6512 NW Crain Hwy. Bowie, MD 20									MD 20	175					
	nysician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interva Between Onset and Death					
	xaminer	Ì	Immediate Cause (Final or condition resulting in				sequence o	f):				_				-	Deam	٦
			Sequentially list condition		b			6 \.						_		-	· .	4
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8760,	ificate l g physi s the bu	n/Me	IF FEMALE: 23b. Was decedent preg	nant in th		es, outco	ome of preg		Fetal death	3	Ectopic	pregnar	ncy	2	3d. Date of del Month	ivery Da	y Year	٦
99 X	nth certi		past 12 months?	Link	4 _ P	regnant a	at time of de	oth _	Other (Spe	h				- 1			•	
-	the dea by the a ched fo	Physicia	Part II. Other significar		9 0	nknown ng to dea	ath but not r	esulting in the	e underlying	ı cause gi	ven in Par	t I.	23e. Di	d tobacc	o use contribut	te to th	e cause of death?	\dashv
P.O.	res that signed l be deta	ð						_					1 🔲	Yes 2	✓ No 3	Proba	bly 4 Unknown	
of Vital Records,	v requir	Completed	_											topsy	prior	r to co	psy findings availabl mpletion of cause of	
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tal	ysician: The his certificate director, page	Be	25. Was case referred to examiner?	to medical	Hospital:	7		ED/0.4-4			of Death (only one) g Home 5	Posi	dence 6 🗸	Othor:	2000	\dashv
of Vi	g Physic Rer this Reral dir	. To	1 Yes 2 27. Manner of Death	No	28a	Pate of In	tient 2	ER/Outpatie		, JA	y at Work	?	28d. Descri	be how i	njury occurred	-	Joene	┪
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Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Certification:	3 Suicide 6	Coul	d not be 28e.	Place of cify) W		ome, farm, st	reet, factory	, office bu	uilding, etc	- 1	or Tow	n. State)	and Number o		i Route Number, City	У
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	al Ce	4 Homicide 29a. Certifier (Check only 1 Cert	tifying Pl	hysician: To the	best of	my knowled	ge, death oc	curred at the	e time, dat	te and pla	ce, and	due to the c	ause(s)	and manner as	stated	1.	┪
	To the H within 24 To the Fi complete	Medical	one) 2 Med		miner: On the band man	asis of ex ner stated	amination a	and/or investi				curred a	t the time, d					_
		Σ	29b. Signature and title	of certifie		1/	î o		29	c. License O.C.N					1. Date signed oril 12, 2008	·	n, ∪ay, Year)	
			30, Name and address	tt	The	17C	u	. 00-1		J. J. IV								_
				or person	who completed	cause of	death (Iten	1 238)										
- ((3)		Margarita Kore	II MD.	Assistant	Medica	al Examir		Penn Sti	reet, Ba	Itimore	, MD 2	21201					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Horace Gilmer White /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Doctor's Hospital Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 18, 1926 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 ★ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Carolina N. 81 Director 246-30-1069 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location r 28a-f sh notified 1 ☐ Yes 2 X No Director Prince George's Bowie MD 10f. Zip Code 20716 10g. Citi: USA Citizen of What Country? 10e. Street and Number a or 15744 Pointer Ridge Dr. ral", or items 23a Examiner must i Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1945–46 1 ☐ Never Married 2 Married 1 □ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White "natural" 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Post Office Postal Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fin and Mental H Be Je, Maryla

Je, Maryla

Jentific Pages 1 and 2 should be be be beartment of Health and Mr Important: If item 27 in any Injury or other pages. Lois Kornegay James Alton White P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15744 Pointer Ridge Dr. Bowie, MD 20716 Ruth H. White / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veteran's Cemetery 4/22/2008 | Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensy Bowie, MD 20715 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 12 hours CARDIAC AMESI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ALUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that the death certificate be executed CORONARY ATHEROSCIENOSIS that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page perforn 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the ...
To the Funeral Diverse ... 29a. Certifier 1 🗡 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated title of certifier 29b. Signature

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signa

Peter M Schissler

31. Date filed (Month, Day Year)

022780

7500 Greenway Ctr Dr. Greenhelt MO20170

State Registrar

21

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4/12/2008 **Physician** Gailey Elizabeth Wiggins 3:45pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 11/10/1942 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 X F 65 ŃC 462-70-4827 Director Usual Residence of Decedent 3a or 28a-f show at be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MDAnne Arundel Severn 1 ☐ Yes XXNo Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1803 Lasalle Pl 21144 USA or items 23a must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. traumatic event, the Medical Examiner 1 ∐ Yes 2 XXXIo If Yes, Give Year or Dates: 1 Never Married 2XXMarried 1 ☐ Yes 2X No Specify: Black ģ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 Homemaker Own Home land 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Horace Davis Geneva Wilcox Baltimore, Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If Item 27 any injury or other tra of Health Item 27 i severn, MD 21144 Douglas Wiggins SR. Spouse 1803 Lasalle Pl 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4/28/2008 Arlington National Arlington, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licens Oahl 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** F. Srillation Ventricular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner peokalemia Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed burial-transi teu (une Chronic renal and resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the as ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ð Noncompliance With 1 Yes 2 No 3 Probably 4 Unknown dialysis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy nerformed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Fafter death. Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 021225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive # 116 6len Burnie, Mg 21061 808 Landmork Stephen M.D. Zemel $\overset{\scriptscriptstyle{Y_{ear}}}{1}5$ gistrar's Signature State Bern Registrar

DHMH 17 Rev 1/2001

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		1 - State Registrar		Spartificate of		Reg. N	71111	9 14221
		1. Decedent's Name (First, Middle, Last)				. Date of Death	3. Time of Death	
	hysician Medical	Isaiah Whitby				April 10	2008	3:19 P M
	xaminer	4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, o	r Location of Death		c. County of Deal	
		Anne Arundel Medical Cent		Annar			Anne Ar	
	neral	1 N 2 0 0 0	Age (In yrs. last birtho	Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea 1/25/191	9. Bir	thplace (State or Foreign ountry)
	ector	Usual Residence of Decedent	95 Yr	3.		1/25/191	3 Pen	nsylvania
yland	MOL THE	10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
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章 ·	Dire	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Co	untry?
death with the Maryland	eral series	3666 Muddy Creek Rd.	· · · · · · · · · · · · · · · · · · ·		1037		USA	
ier de	iber sust	11. Marital Status 12. Was Deceden Armed Forces 1 Never Married 2 Married 1 Yes 2	nt Ever in U.S.	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Specit an, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
Maryland 21215-0036 at 2 should be filed within 72 hours att ifth and Mental Hygiens.	yd yd			1∐Yes 2∭XNo	Specify:		Specify:	Black
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re,	other	20a. Method of Disposition	20b. Place of D	isposition (Name of	ceek Rd., E		Location - City or	
mo Pages ento	ر م	1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	e Kalas	crematory or other place Crematory	4/ 13/	′08 Ed	gewater,	MD
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	in i	21. Signatu Properties Censee		22. Name and Addre	ss of Facility Geo			eral Home
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		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not	t enter the mode of dyir	ng, such as cardiac or r	espiratory arrest,		Approximate Interval Between
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O. B. he dear	ed for	in the past 12 months?	at time of death	5 Other (specify)	у		Month	Day Year
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Red e law	irector, page 2 s					24a. Was an autopsy	prior to	topsy findings available completion of cause of
al H	C. pag					performed?		2 🗆 No
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Division of 1 or Attending Phy after death. Director: After this	funeral dirution: To	27. Manny of Death 28a. Date of In	tient 2 LER/Outpa jury 28b. Tim	ne of 28c. Injur	4 Li Nursing Home	5 Nesidence I. Describe how inj		cify)
NVISION or Attending after death. Director: After	e fun	1 √ Natural 5 ☐ Pending (Month, D 2 ☐ Accident investigation	<i>Pay, Year)</i> Inju		₹? Yes 2 □ No		,	
Visio • Attendi er death.	by th	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Ir	njury - At home, farm, etc. (Specify)	, street, factory, office	28f.	Location (Street a	and Number or Ru	ıral Route Number,
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Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director. A	ely fill	29a. Certifier (Check only (Ch	t of my knowledge, d	leath occurred at the tir	me, date and place, and	d due to the cause	(s) and manner as	s stated.
To the A within 24	этріетеїу fil Medical	and manner s	stated.					
ob wit	8	29b. Signature and title of certifier	X	29c. License	e number	29d. L	ate signed (Monti	n, Day, Can
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14	WY.	30. Name and address of person who completed cause of			Δ	ALL MAI	2140	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22, **Physician** 2008 9:25 AM JR. April LEROY WALLACE CHESTER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6/15/1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Pennsylvania Director 216-24-6237 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a. State 10b. County 1 □Yes 2X No MD. Harford Bel Air Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 21015 United States 8 Corns Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: **Korea** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Introductant: If item 27 is marked other than "natural"; or iter amy injury or other traumatic event, the Medical Examiner and. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 5 Black 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Elementary/Secondary (0-12) College (1-4or 5+) Proving Ground PX Stockman 18. Mother's Name (First, Middle, Maiden Surname) ore Maryland 17. Father's Name (First, Middle, Last) Be Wallace Stewart Chester Anna Andrew Ruth ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21154 Edna W. Holland (Sister) 419 Glasgow Road Street, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Harford Mem. Gardens 4/28/08 Aberdeen, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardiac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Discase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the Udallace Chester MOCOCOS as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Hypertension page 2 should Completed peen Kena 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate Diabetes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No 1 Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital c within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addy ess of person who completed cause of death (Item 23a) (Type, Print) M.D. 500 Upper Chesappake Dr. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depa 1- State Registrar State of Maryland / Depa	rtment of Health and tificate of Death		ne . No. 2008	14223				
	Physicia	_	1. Decedent's Name (First, Middle, Last) Mary Ruth Woodburn		2. Date of Death Month April 24	Day Year	3. Time of Death 11:45 P M				
	/Medic Examin	mer i	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death					
	Funeral Director		20401 Piney Point Road 5. Social Security Number 216-12-4397 1 □ M 2 ★ F 7. Age (In yrs. last birthday) 87 Yrs.	Callaway If Under 1 Year If Under 24 Hrs Months Days Hours Min			ry's place (State or Foreign intry) [aryland				
	land ow at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits				
	e Mary Ba-f sh tiffed a	ctor	Maryland St. Mary's	Callaway							
	h with th 23a or 24 st be no	al Dire	10e. Street and Number 20401 Piney Point Road	10f. Zip Code 20620	10g	. Citizen of What Cou USA	intry?				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy hurry or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 📉 No	As Decedent of Hispanic Origin? (: Yes, specity Cuban, Mexican, Pue Yes 2 No Specity:	Specify Yes or No- rto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: White					
21215-0036	I within 72 ho jiene. r than "natur the Medical B	Completed by	(Specify only highest grade completed) (Give le	ent's Usual Occupation kind of work done during most of wo IO NOT use retired) ales Clerk	orking	16b. Kind of Business/Industry					
pu	be filed tal Hyg d other event,	Be	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma	,					
Maryland	should nd Men marke imatic	은	George Leonard Stone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing	g Address (Street and Number or F	se Etta Den Rural Route Number, C		ïp Code)				
, Ma	and 2 sealth ar n 27 is ner trau			Piney Point Ros		vay, MD 20					
Baltimore,	t. Pages 1 tment of H tant; If Iter fury or oth		20a. Method of Disposition 1월 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposic cemetery, crem. Holy Face Co	emetery	cil 28,	Great Mills,					
Ba	Departiment Depart	s 15	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Name and Address of Facility Mattingley-Gardiner P.O. Box 270 Leona	Funeral Home	P.A. 20650					
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and any heading to minedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Complete (or as a consequence of): Due to (or as a consequence of):									
Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Exa	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year				
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Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2⊠ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other:	eath (Check only one) Home 5 🖾 Residen		cify)				
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DIX	al or At after d I Direct d in by	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	City or Town,	et and Number or Ru State)	rai Houte Number,				
	the Hospital or hin 24 hours afte the Funeral Dir ppletely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invariant and manner stated.								
	To th within	Me	29b. Signature and title of cerufier Amount arms 1	29c. License number D 0641	19	1. Date signed (Month	1 52-5				
	DA		30. Name and address of person who completed cause of death (Item 23a) (Type, I James P. Jarboe, M.D. 24035 Three N	otch Road Holl	Lywood, MD	20636					
ľ	Sta Regist		31. Date filed (Month, Clay, Year) APR 2 5 2008	med							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 5:46 M **Physician** 2008 April 14, John Charles Yates /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 111 Chestnut Avenue Washington Grove Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 🔀 M 2 🗆 F 10, 1930 Maryland Director 217-28-8228 Dec. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hyglene. 7 is marked other than "natural", or ifems 23a or 28a-f shov traumatic event, it is in Section in an initial to incline a standard event, it is inserting the months of a 1 ☐ Yes 2 No Director Maryland Washington Grove Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20880 USA 111 Chestnut Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XX No SpecifyWhite Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Vice President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Blakemore Francis Yates ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Christina Currier/Daughter Chestnut Avenue, Washington Grove, MD 20880 altimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 18 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 22. Name and Address of racinity
Francis J. Collins Funeral

500 University Blvd, W, Silver Spring, MD 209

Approximate
Approximate
Interval Between
Onset and Death 21. Signature Funeral Service Licensee leer MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician aRespiratory Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bChronic Obstructive Pulmonary Disease Due to for as a concequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed Ischemic Cardiomyopathy attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Ö cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 K No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D18813 April 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Avenue, Silver Spring, MD 20902 Ira Tauber, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 16 APR 2008 Registrar

08-02972 Guy Douglas Allenb	oau	Please Typ	oe or Print i	and / D	epartm	ent of	Health	ure and	All Co Menta	pies al Hygi	Are Legik iene	ole.	200	8 1422
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x 6 th cert	sicia			•	ime of death	5	Other (Spec	cify)				1		
Bo e deal the al	اح		3 0	nknown	but not resi	ulting in the	e underlying	cause	given in P	Part I.	23e. Did to	bacco use co	ontribute t	the cause of death?
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Division of Vital Rec pital or Attending Physician: The I ours after death. eral Director: After this certificate I	Bec	25. Was case referred to med examiner?			[3]		(_	e of Death			Residence	6 Oth	er:
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or Ay	Certification:	3 Suicide 6 X	Could not be					y, onice	, pulluling,	O.C.	or Town, S	State) Idletown	Rd.	Annapolis, MD
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		30. Name and address of pe Melissa Brassell, N		Medical	Examin	er 11	1 Penn S	treet,	Baltimo	ore, MD	21201			
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		For State Registrar	State of	Maryland /	-	rtmen			and M		giene Reg. No:()	0000)	11.225		
-	do.	Hegistrar Decedent's Name (First, Middle, La	st)							2. Date of De	ath	. U U C		3. Time of Death		
Physici		MIRIAM				ARMO	N			Month 4	Day 2	Year 08		02; 209M		
/Medic Examin		4a. Facility Name (If not institution, giv	e street and num	nber)		4b. City,	4b. City, Town, or Location of Death					County of De				
	3	Sinai Mospital i	7 Balti	move.		130		we.				BALTIN				
Funeral Director		5. Social Security Number 6. S 217-18-6962	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Bir (Month, Date 12/04)	th <i>Yy, Ye<i>ar)</i> 1923</i>	9. Birthplace (State or Foreig Country) MD						
P.		Usual Residence of Decedent		10c. City, To	own or Lo	cation							10d.	Inside City Limits		
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be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	'e		1 □ Yes				,			WHIT			
2 hour		15. Decedent's E	ducation	1	6a. Deced	dent's Usua kind of wo	al Occupa	ation	et af warki	ina	16b. Kin	d of Busines	ss/Indus	try		
be filed within 72 ho ital Hygiene. Id other than "natu event, the Medical	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	DO NOT u	se retired,)	SI DI WOIKI	ng		r. r				
filed within Hygiene. other than ent, the M	S	12					OWNE		or's Name	(First, Middle	Maidan		ETAI	<u>L</u>		
	Be	17. Father's Name (First, Middle, Last MARTIN)	S	ANDLE	- R			GERTR	,	, maidon e		RAMS	ON		
d 2 should be fi th and Mental H 7 is marked ot traumatic ever	P	19a. Informant's Name/Relationship	Type. Print)				(Street a			al Route Numb	ber, City or					
		JACK ARMON / HU	SBAND		6350	RED	CEDAI	R PL <i>F</i>	∖CE,	#308,	BALTI	MORE,	MD	21209		
ges 1 and of Health		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Bemoval from	ceme	etery, crei	sition (Nar	ther plac	e)		Date		cation - City				
Pag tment tant: I		4 Denation 5 ☐ Other (Speci	fy)	B. NA		RAEL				/2008		TIMOR	_			
permit. Pages Department of Important: If if any injury or once.		1. Signatur of Funeral Sorvio	osee /	`		2. Name ar			50	ROAD -			-	INC. D 21208 _		
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that c	aused the death.		3900_ ter the mod						ZATEL		pproximate hterval Between		
Physician		shock, or heart failure. Elst only Immediate Cause (Final disease or condition	one cause of e	Pro vessi	. A	nemi)						Ö	Onset and Death		
/Medical		resulting in death)	Due to	(or as consequen		VCENTO								2 pags		
Examiner	IJ	Sequentially list conditions, if any, leading to immediate	bC	regestive	- h	cart	flu	leire	,			-	1	oyrs_		
ng Age	njne	if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events	Due to	(or as a consequen	ice oi):		V							lux.		
be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consequen	ALLEIA ice of):	<i>Q</i>								72		
ate be only sicial ne buri	ical		d										_			
death certifical attending phy		IF FEMALE:	00 1/													
ath ce	sician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	tcome pf pregnancy pirth 2 ☐ Fetal de nant at time of deat	eath 3[☐Ectopic p		/			2	23d. Date of Month	,	ay Year		
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkn		00											
s that ned b	by Phy	Part II. Other significant conditions	contributing to d	eath but not resultir	ng in the u	nderlying o	ause give	en in Part	I.	23e. Did	tobacco u	se contribute	e to the	cause of death?		
en sig		Atrial fibrilla	from C	tronary	arte	ry o	lisea	R		1	Yes 2	XNo 3□] Probat	oly 4 □Unknown		
law relas be	Completed	Diabeles Malli	trus,	V		0					opsy	prior	to comp	sy findings available pletion of cause of		
The cate h	Con									1□ Yes	_^	death	res 2	□No		
ician certifii ector	Be	25. Was case referred to medical examiner?	Hospital:	(Oth	or.	_	th Check onl		- Cou	2			
Phys	.: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury 28	3b. Time o	nt 3□ D	28c. Injur Wor	4 L N	lursing Ho	ome 5 Res 28d. Describe			эреспу)			
nding ith. r: Afte	ation	1∕X√Natural 5 ☐ Pending 2 ☐ Accident investigation		nth, Day Year)	Injury	М		κ? Yes 2∐]No							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 ☐ Suicide 6 ☐ Could not determined	200. Flace	e of injury - At home ling, etc. (Specify)	e, farm, st	reet, facto	y, office				(Street an own, State		r Rural I	Route Number,		
pital ours a meral of filled i		29a. Certifier 1 Certifying F	hysician: To the	e best of my knowle	edge, dea	th occurre	d at the til	me, date a	and place	, and due to th	e cause(s)	and manne	r as sta	ted.		
ne Hos ne Fur pletely	Medical	(Check only 2 Medical Example)	aminer: On the b	pasis of examination oner stated.	n and/or i	nvestigatio	n, in my c	opinion, de	eath occu	rred at the time	e, date and	d place, and	due to t	he cause(s)		
To th To th comp	M	29b. Signature and title of certifier						se number				te signed (M				
1		May				R	ES-	000)		04	, 29,	20	15more MD		
12		30. Name and address of person wh	completed caus	se of death (Item 23	3a) (Type	, Print)	الله		211-	1 (1) 10 -	honda	o Ann	0.	Thomas has		
∜St	ate	31. Date filed (Month, Day, Year)	/ (A)2. F	Registrar's Signatur	e de		XIM	note,	40	1.N.130	(V KOLE)	u nve	, Da	CINI BROINICH		
Regist		MAY 0 1 20	18	18 JO	100	act of								UUS		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 Day Month **Physician** rown 4c. County of Dea /Medical 4a. Facility Name (If not institution, give street and number) Location of Death 4b. City. Town. Examiner Kansa HIMO 8. Date of Birth (Month, Day Year) If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 215-46-5988 1 1 M 2 1 F 59 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Des 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2000 amsa Funeral death 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Ences? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 2 No 1 ☐ Tes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Blac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) aborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be other traumatic ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a important: If item 27 is any injury or other tran 20b. Place of Disposition (Name of cemetery, crematory or other 20a, Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State rounsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final 1623 **Physician** Metastatic Non Small Cell Carcinomast the Luna /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte the detached for in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

Ves 2 No 1☐ Yes after death.

Director: After this certific in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗑 Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No NA 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours are To the Funeral Dir 29a. Certifier 1 🖲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) 2008 MAY 01

29b. Signature and title of certifier

Robert A Bourthe

ION. Breene gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Balt.

26817

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕕 🕕 🖔 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Vear **Physician** 5:30 AM Brinkman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facifity Name (If not institution, give street and number) Examiner Baltimore Elizabeth N/A ff Under 1 Year | If Under 24 Hrs. 8. 3. Date of Birth (Month, Day, 1918) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 XM 2 □ F 89 Maryland 212-03-9435 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 27 Is marked other than "naturel", or Items 23a or 28e-f show treumstic event, the Medical Examinar must be motified at treumstic event, the Medical Examinar must be motified at 1 ☐ Yes 21 No Maryland Baltimore Arbutus Director 10e. Street and Number 5550 Oakland Rd. 10g. Citizen of What Country? 10f. Zip Code 21227 **USA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item any njury or other treumatic event, the Madical Exempens. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Contractor 12 Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin G. Brinkman Ida Johnson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship *(Type, Print)* Gail M. Jones, daughter 9413 Tiller Dr. Ellicott City, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Meadowridge Memorial Park 05-01-08 Elkridge, MD 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Neumonia **Physician** dow disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,てら burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Vear Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown à ate has been signed to page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No this certificate : After this certifica s funeral director, p the Hospitel or Attending Physician: 25. Was case reterred to medical examiner? 26. Place of Death (Check only one, Be Hospitaf: Other: 2X No ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death
1 Natural
2 ☐ Accident 28c. fnjury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and mainer. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 3320 Min nue

State

Registrar

31. Date tiled

enson

2. Registrar's Signature

1 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland / Department of Health a Certificate of Death		Reg. No. 200	14229		
П	Physicia	an	1. Decedent's Name (First, Middle, Last) Edward Benkovic	2. Date of Dea Month April	29 2008 ear	3. Time of Death 10:04 PM		
may .	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of		4c. County of Dea Balti	th		
***			Gilchrist Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	4 Hrs. 8. Date of Birth		thplace (State or Foreign		
ı	Funeral Director		193-16-3916 1X M 2 F 82 Yrs. Months Days Hours	4 Hrs. 8. Date of Birth Min. 10-19-	1925 Per	inslyvania		
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	he Mar 28a-f sh ptified	ector	MD Baltimore Towson		10g. Citizen of What Co	1 ☐ Yes 2X☐ No		
	h with ti	al Dir	10e. Street and Number 109 Swarthmore Drive 10f. Zip Code 21204		U.S.A			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrainer must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Original Interval of Hispanic Original Interval	in? (Specify Yes or No- Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036	n 72 ho "natur edical	oleted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	of working	16b. Kind of Business	/Industry		
212	ed withii ygiene. er than t, the M	Comp	12 College (1-4or 5+) Sales Manager		Liquor In	ndustry		
Baltimore, Maryland	d be file ental Hy ked oth c event	To Be	17. Tathor of tatho (* 114)	's Name (First, Middle, Brie Jurkov				
lary	2 shoul and M is mar raumati	F	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number					
re, l	s 1 and f Health item 27 other t		Pamela Gebhart / Daughter 296 Evergreen Dr., 20a. Method of Disposition (Name of Disposition	Apt. 2, No	20c. Location - City or			
imo	Pages Iment o tant: If jury or		4 Donation 5 Dother (Specify)	05-02-2008	Timoniu			
Ball	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Rd.,	Towson, MD	21204	Home, Inc.		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as o shock, or heart failure. List only one cause on each line.		rest,	Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death) a. The disease of condition resulting in death) Due to (or as a consequence of):			1- c		
	Examiner	ē	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): C. Due to (or as a consequence of):	169		0075		
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	rte		years		
68760,	rtificate be executed g physician and as the burial-transit	edical E	d.					
89 x	certifica ding ph se as th		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	divorv		
P.O. Box	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Ves 2 □ No 9 □ Unknown 9 □ Unknown		Month	Day Year		
	w requires tha s been signed should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute t ⁄es 2 ☐ No 3 ☐ E	o the cause of death?		
Reco	The law recate has bee page 2 sho	Completed		24a. Was autop	prior to death?	utopsy findings available completion of cause of		
ita		Be Co	25. Was case referred to medical examiner?	1 ☐ Yes of Death (Check only o		s 2□No		
of <	Physic this ce al dire		1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nur	rsing Home 5 Resid		ecity) hospile		
ion	Attending Physician: If death. ector: After this certificity the funeral director.	ation:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day, Year) 28a. Date of Injury 28b. Time of Injury 4 Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ N		now injury occurred			
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox	Street and Number or F vn, State)	lural Route Number,		
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Check only one Check one Chec					
	To the within To the comple	Me	29b. Signature and fittle of certifier 29c. License number 0 583		29d. Date signed (Mon April 30			
	10x,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON J CHANGES NO 6701 N-Charles ST 78	DASKN 6	ng 2120	4		
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature			/		

Registrar

MAY UI ZUUS LEDEUR JE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10f,18,20&c&22 Per FH C879 5/06/08 JH Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 0050 AM Nina Barnes /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country)

June 29, 1916 | North Carolina If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 ☐ M 2 💢 F 240-44-3872 91 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1√2 Yes 2 □ No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 **2121**8 USA 2727 N. Charles Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No black Specify 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) residential domestic 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be John Chamberlain ပ Couvenia Chamberlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7008 Independence Street Capitol Heights, MD 20743 Herman Cannon/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State Mt. Carmel 5/06/2008 Baltimore, MD 4□Donation 5☑Other/Specify) in state 22. Name and Address of Facility
State Anatomy Bass 655 W. Baltimore Street
Raltimore, MD 21201 4300 Wabash Ave
Approxima 21. Sinn ture of Euneral Sauce Licensee ROT 210 S. Wada, irector Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) herosc SCUST **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2D No 9☐ Unknown Month 4⊡Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has the rector, page 2 s autopsy performe death? 1 ∐ Yes 2 □ No 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire 1 Tes 3D DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and fills of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar

State

31. Date filed (Month, Day,

0 1 2008

Rygistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reginald Orlando		les 1- For State	State	of Maryla		partmen <i>ertificate</i>		Health and Death	d Menta	l Hygie	ene Reg	No	200	18 11.23
Physicia		Registrar 1. Decedent's Name	e (First, Middle,Las	t)							ate of Death		Year	3. Time of Death
Medical Examir	ıer			Regi		Orla		. City, Town, or I	les	A	onth pril 26, 20		ounty of Deat	1724 hrs
1		4a. Facility Name (i 1 Kent Name		e street and nu	mper)		- 1	Parkville	Location of t	Death			timore Co	
Funeral	11	5. Social Security N	lumber 6. S	эх	7. Age (In y	rs. last birthda	y)	If Under 1 Year		_	Date of Birth	(MM/DD	/YYYY) 9. Bi Forei	rthplace (State or
Director	-	214-80-	3572 x	M 2 F	4	17	Yrs.	Months Days	Hours	Min.	4-18-	-196		ountry) MD
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aryland	Director	10e. Street and Nu	mber				Т	10f. Zip Code			100	g. Citizen	of What Co	untry?
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Marri	ed 2 Married	12. Was Dec Armed F	orces?		3. Was	Decedent of His s, specify Cuban	panic Origin , Mexican, F	i? (Specify Puerto Rica	y Yes or No- an, etc.)	14	. Race - Ame White, etc.	erican Indian, Black,
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Box 6876(e death certificate the attending phy.	cian	past 12 month		1 Live	nant at time	of death 5	=	al death 3 er (Specify)	ctopic	pregnancy		"		50,
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i, P.O. ires that the signed by	by P	Part II. Other sign	ificant conditions	contributing	to death but	not resulting i	n the ui	nderlying cause	given in Par	t I.				robably 4 Unknown
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tal Records cian: The law requi certificate has been ector, page 2 should		25. Was case refe	rred to medical					26.Plac	e of Death (Check only	1 Yes	2 No	1 🗸	Yes 2 No
1 of Vital Rec ling Physician: The After this certificate funeral director, page	o Be	examiner?	2 No	Hospital: 1	Inpatient	2 ER/Outp	atient	3 DOA	Other _	Nursing H	lome 5	Residen	ce 6 🗸 Ot	her: Scene
of Vi ing Physi After this	-	27. Manner of Dea		28a. Date	e of Injury h, Day,Year)	28b. Tir			ury at Work?	le.	d. Describe h		y occurred	
ion ttendi death.	atio	1 Natural 2 Accident	5 Pending Investiga	tion Apr 26	2008	1720 h	nrs		Yes 2	No				Devel Developher City
Division of Vital Records, tal or Attending Physician: The law require rs after death. *I Director: After this certificate has been silted in by the funeral director, page 2 should be an order or the funeral director, page 2 should be as the funeral director.	Certification:	3 V Suicide	6 Could no determin	ot be	ce of Injury - Single		n, stree	t, factory, office	building, etc				t, Parkville,	Rural Route Number, City MD
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b		4 Homicide 29a. Certifier (Check only	Certifying Physi	cian: To the be	est of my kno	wledge, death	occuri	red at the time, o	date and plac	ce, and du	e to the caus	e(s) and	manner as s	tated.
Fo the vithin. Fo the comple	Medical	one) 2 🗸	Medical Examin	er: On the basis and manner	of examinat stated.	ion and/or inv	estigati			curred at th	e time, date			
	ž	29b. Signature an	d title of certifier	10 0	1)				se number				ate signed (/ 27, 2008	Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02705 State of Maryland / Department of Health and Mental Hygiene David A. Carpenter 2008 14232 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Year Month 0720 hrs Medical Examiner April 6, 2008 David Carpenter Α 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's District Heights 6810 Clinton Manor Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** oreign Country) MD Months Days Hours Director Feb 9, 1956 220 62 9135 52 1 XM 2 Usual Residence of Decedent 10d, Inside City Limits any 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 XX No 28a-f show s 23a or 28a-f show s notified at once. MD Charles Nanjemoy Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20662 United States 9010 Riverside Road uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 1 X Yes 1 Yes 2 X No specify: Specify: White Widowed 4 Y Divorced marked other than "natural", ic event, the Medical Examiner \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) permit Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n
injury or other traumatic event. the Medical F Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 12 Boiler Maker Welding 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Carpenter Lucille Kidwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean Tyson (Daughter) 458 Glenmar Road, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) April 20a. Method of Disposition 15,2008 1 XXBurial 2 Cremation 3 Removal from State Camp Springs, MD Bell Methodist Church Cemetery Donation 5 Other Specify 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD Approximate Interval 239 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Complications of chronic alcohol abuse Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and hysician/Medical UNPENDED AMENDED physician Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy the 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 Unknown death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ Yes 2 ✔ No 3 Probably 4 Unknown Completed ificate has been sir, page 2 should b 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 26.Place of Death (Check only one) 25. Was case referred to medica funeral director, Be examiner? Hospital: Other; Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification 1 V Natural Yes 2 within 24 hours after death.

To the Funeral Director:
completely filled in by the f neral Director: filled in by the f Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Medi and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 7, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (tem 23a)

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State

Registrar

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year

MAY

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Assistant Medical Examiner

32. Registrar's Signature

Bellever

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03268 State of Maryland / Department of Health and Mental Hygiene Michael Henry Chapman 1- For State Certificate of Death Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day April 28, 2008 1421 hrs Medical Examiner Michael Henry Chapman c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Woodlawn 1660 Whitehead Court Room 406 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 5. Social Security Number Funeral Foreign Hours Days Months 1951 Country)Maryland Oct. 21, Director 213-58-3777 $_{1}X_{M}$ 56 Yrs 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 X No Baltimore Owings Mills or items 23a or 28a-f show must be notified at once. Maryland 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number United States 21117 ō 4630 Kings Mills Way Limore, MD 21215-0036

. Pages I and 2 should be filed within 72 hours after death with to the filed within 72 hours after death with to the filed than Mental Hygiene.

The filed 27 is marked other than "matural", or items 23a or other traumatic event, the Medical Examiner must be not 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Yes 2XX No Specify: White Yes 2 X No specify: f Yes, Give Yea 4 X Divorced Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Nursery Garden 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Herbert Walter Chapman Frances Lucille Cox Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 4630 Kings Mills Way, Owings Mills, MD 21117 Mary T. Collard (former wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State May 2, 2008 Ellicott City, MD Shepherd Cemetery Go $^{\mathrm{bd}}$ Donation 5 Other Specify. 22. Name and Address of Facility Loring Byers Funeral Directors, permit. 21. Signature of Funeral Service Licensee 8728 Liberty Rd., Randallstown, MD 21133-4784 10033 24. Part I. Enter 6 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on Death Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 ✔ Unknown ٥ Chronic alcohol abuse Completed 24b. Were autopsy findings available 24a. Was an peen prior to completion of cause of autopsy death? performed? has 1 🗸 Yes 2 No ✓ Yes 2 certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be Other4 examiner? Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 Inpatient 2 After this 1 V Yes 10 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification: within 24 hours after accass.

To the Funeral Director: A 1 V Natural 1 Yes 2 No 5 Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 29, 2008 O.C.M.E. rassec

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Registra

Melissa Brassell, MD
State 31. Date filed (Month, Day, Year

MAY 0

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2008

OCME

r's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0118 **Physician** Adeline umD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Leorge's Hospital Center trince Chererly (ILOYAE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1□M 2ØF (arolina 239-56-2684 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County 23a or 28a-1 ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heelth and Mental Hygiene.
ent: If Item 27 Ie marked other then "natural; or Items 23a or 28a-1 ehov ury or other treumstic event, the Medical Exa ulter count by notified at LF Yes 2 No MD rever Be Completed by Funeral Director Leorae trince 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United 20785 2900 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Services aundry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Montague 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chesapeake 1224 Triple Crown Lircle Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Depertment of H Importent: If Ite eny Injury or of 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 MOTher (Specify) in state 21. Signature of Fungue Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part \(\) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Kenal Immediate Cause (Final Stage Discase End **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Completed by Physician/Medical Examiner the attending physicien and ned for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed) tailure Kebbiratory 1 ☐ Yes 2 2 No To the Hospital or Attending Physicien: 25. Was case referred to me lical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 ☑Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D01852 4-20-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hyatsville MD 20781 Road Queensbury verore. 4203

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 1

32. degistrar's Signature

2008

08-02898 JAMES T. PANIELS
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day April 13, 2008 0732 hrs Medical Examiner me 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Middle River Davison Road and Langley Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign outh Min Director 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Yes 1 Yes 2 No specify: Specify: If Yes. Give Year \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) If item 27 is marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) rovane 100 e To. daughte Kisha 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 2 Cremation 3 or other Removal from State Burial Donation 5 Other Spe 22. Name and Address of Facility 21. Signature of Funeral Service Licensee imarch Fill. Parl . Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and in re. List only one cause on each line. /Medical Death a Sharp and Blunt Force Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - trans Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 ✔ No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? After this certificate has death? 1 🗸 Yes 2 26.Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other; Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject assaulted FOUND: Natural Yes 2 V No Pending within 24 hours after death. To the Funeral Director: Director: d in by the f Apr 13, 2008 0726 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) Davison Road and Langley Road, Middle River, MD completely filled determined (Specify) Construction Area 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

29b. Signature and title of certifier

Carol Allan, MD

30. Name and address of person who completed cause of death (Item 23a)

7"2008

Assistant Medical Examiner

OCME

Registrar's Sign

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 14, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 2008 ar DONEN 29 2:45P abraham 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE 623 KAHN DRIVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 02/02/1928 Birthplace (State or Foreign Country) 5. Social Security Number Days Months Hours 1 Ø M 2 □ F MD 80 220-20-3869 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 623 KAHN DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2□No COAST WHITE 1∐Yes 2∭XNo Specify: 3 Widowed 4 Divorced GUARD Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) SOCIAL SECURITY COMPUTER OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DONEN Sarah ARANOW FRANK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 623 KAHN DRIVE, BALTIMORE, MD DORIS DONEN / 20b. Place of Disposition (Name of SHOMRE Tremplet Place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 04/30/2008 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) TZEMECH SEDEK Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final A Now I disease or condition resulting in death)

Physician /Medical Examiner

physician and the burial-transi

attending properties for use as

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signed by t I be detach

has e 2 s

page certificate

director,

After th funeral

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f hours after death.

The law requires that the death certificate be executed

Box 68760,≪

P.O. I

Division of Vital Records,

To the Hospital or Attending Physician:

Physician

Examiner

Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the McClout Examiner must be nutified at

Hygiene.

th and Mental Hygier 7 is marked other the

of Health a

If Item 27 is

permit. Pages
Department of
Important: If It
any injury or o

Pages 1 and 2 should be 1

illed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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MD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

52	a	(and amy agarty
1	b	Due to (or as a consequence of):
4	C.	Change Rann Ins.
	d	Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant

Physician/Medical

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Completed

Be

Certification: To

Medical

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 □ Yes 2 □ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medica examiner? 1 Yes 2 UNO

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

27, Manner of Death 1 Natural 2 Accident

3 Suicide

4 ☐ Homicide

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature a title of certifier

29c. License number

29d. Date signed (Month. Dav. Year)

State Registrar

31. Date filed (Month, Day, Year)

MAY 0 1 2008

dess of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear Month **Physician** Romeo P. Esposito 08:12 P M 2008 April 29 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center **Baltimore** Towson 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 12-29-1919 5. Social Security Number **Funeral** 1**X**□M 2□F 218-07-6601 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD Towson 1 Tyes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 705 Camberley Circle 1A 21204 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing & Textiles Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giulio Esposito Concetta Palmerino ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 Camberly Cr., 1A, Towson, MD 21204 Rose Esposito / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 05-03-2008 Dulaney Valley Timonium, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARREST . PACEMAKER Physician CARDIAC /Medical Due to (or as a consequence of): Examiner MYASTHENIA GRAVIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit HEART FAILURE CONGESTIVE Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown BOWEL ENTERECTOMY ISCHEMIC 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an BNASTO MUSIS 1□ Yes 2No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

6701 NORTH CHARLES STREET SUITE STOU. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K 11 N

Cin Win Mymil

and manner stated.

29c. License number

WIN MYINT

TOWSON

29d. Date signed (Month, Day, Year)

21204

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2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2008 7:45P. Emmanuel Henry Franklin 25 Apr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/ABaltimore 1411 Madison Avenue 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. Maryland 1**X** M 2 □ F 1925 21, Director 219-16-2995 82 May Usual Residence of Decedent 10c. City, Town or Location Baltimore 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at once. 10a. State 10b. County Maryland N/A Yes 2 □ No Director 10g, Citizen of What Country? 10f. Zip Code 21217 10e. Street and Number 1411 Madison Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1943 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 1946 Specify: à 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Manufacturer Elementary/Secondary (0-12) College (1-4or 5+) Laborer 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Grace ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7112 Bexhill Road Baltimore, Maryland 19a. Informant's Name/Relationship (Type. Print) Bess McCallister/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest 20c. Location - City or Town, State 20a. Method of Disposition vet.5/08 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Foneral Service Licenses 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. En a carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Vear 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, Attending Physician:

altimore, Maryland 21215-0036

State ^aRegistrar

Pan 17. 31. Date filed (Month, Day, Year) MAY 0 2008

29b. Signature and title of certifier

701 worth Ran gistrar's Signature 32.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Than Poon

29c. License number

D 57088

29d. Date signed (Month, Day, Year)

30,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	Certificate of Beatif	Reg. No. 2 0 0 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2
#Hiysician Medical Examiner		s	Month Day Year 1650 hrs
	4a. Facility Name (if not institution, give street and numbe Saint Agnes Hospital		f Death 4c. County of Death N / A
Funeral		age (In yrs. last birthday) If Under 1 Year If Under	r 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	217-76-7516 1 M 2 XF	49 Yrs. Months Days Hours	Min. Apr. 4,1959 For Mary land
, fo	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
d how any	Maryland N/A	Baltimore	1 X Yes 2 No
the Maryland as or 28a-f sh iified at once	10e. Street and Number	10f. Zip Code 21216	10g. Citizen of What Country?
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last)	18.Mother	's Name (First, Middle, Maiden Surname)
215. Pe filec ntal Hy rked of cnt, th	Nathan Turner		len Furrs
o can Med 2		19b. Mailing Address (Street and Nun 2629 W. Lafaye	nber or Rural Route Number, City or Town, State, Zip Code) tte Avenue Baltimore, Md 21216
e, MD I and 2 sho Realth and item 27 is	20a. Method of Disposition	20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
mor Pages] ent of If	1 XBurial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	King Memorial 101	K
Baltimore, permit. Pages 1 at Department of Hee Important: If ite injury or other tr	21. Signature of Funeral Service Licensee	22. Name and Address of Facilit	Chatman-Harris Funeral Home stown Road Baltimore,Md 2121
	282. Part I. Enter the disease, or complications that caus	sed the death. Do not enter the mode of dying, such as a	cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician 'Medical	failure. List only one cause on each line.	(methadone and morphine) intoxi	Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Narcotic Due to (or as a condition)		
<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	onsequence of):	
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3760 ficate b g physis s the bu		tcome of pregnancy	oic pregnancy Month Day Year
Box 6876(e death certificate the attending phy ed for use as the the	past 12 months? 4 Pregnar 1 Yes 2 No 9 V Unknown 9 Unknown	at at time of death 5 Other (Specify)	
J. Bo the dea	Part II. Other significant conditions contributing to d		Part I. 23e. Did tobacco use contribute to the cause of death?
s, P.O. iries that the signed by d be detach	Cocaine use		1 Yes 2 No 3 Probably 4 Unknown
ords, w requir s been s should l	Acquired Immunodeficiency	Syndrome (AIDS)	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
Division of Vital Records, tal or Attending Physician: The law requirer art after death. The Director: After this certificate has been signed in by the funeral director, page 2 should by the funeral director.			performed? death? 1 Yes 2 No 1 Yes 2 No
of Vital Recing Physician: The later this certificate Luneral director, page	25. Was case referred to medical		h (Check only one) Nursing Home 5 Residence 6 Other:
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nding hth.	1 Natural 5 Pending Find //	28/2008 Fnd : unk	X No unk
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Division o spital or Attending tours after death. neral Director: Aft filled in by the fune	4 Homicide determined (Specify)		unk
	Certifying Physician: To the best (Check only one) Medical Examiner: On the basis of	of my knowledge, death occurred at the time, date and examination and/or investigation, in my opinion, death	occurred at the time, date and place, and due to the cause(s)
5 to 18 kill	and manner sta 29b. Signature and title of certifier	29c. License number	
N.	lahnn	O.C.M.E.	April 29, 2008
Hop	30. Name and address of person who completed cause Zabiullah Ali, M.D. Assistant Medica	f death (Item 23a) I Examiner 111 Penn Street, Baltimore	, MD 21201
Sta	20 Boo	trar's Signature	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 12-30 CM 2008 **Physician** APRIL 26 Bertha Mae Foreman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Future Care If Under 1 Year If Under 24 Hrs. B. Date of Birth Months Days Hours Min. July (Month, Day Oear) 1982 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🖫 F 229-38-9426 Director Virginia Usual Residence of Decedent 10d. Inside City Limits Maryland 10b. County 10c. City, Town or Location 28e-f shov traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No N/A Director Maryland the 10g. Citizen of What Country? 10f. Zip Code 21223 10e. Street and Number 1812 W. Saratoga Street USA Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Black 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 ŏ Specify þ 3 Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City e filed within 7 al Hygiene. I other then "r Elementary/Secondary (0-12) College (1-4or 5+) Court House Custodian 9th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle Last)
Earl Tankard ages 1 and 2 should be filt nt of Health and Mental Hy t: If item 27 Is marked oth Tobitha Burkes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1812 W. Saratoga Street Baltimore, Md 21223 19a. Informant's Name/Relationship (Type, Print)
Gregory Foreman/Son other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of h Lansdowne, Maryland Burial 2 ☐ Cremation 3 ☐ Removal from State 5/1/08 zion Cemetery ō permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chatman-Harris Funeral Home 22. Name and Address of Facility Chattillan - Hattis Filmeral Ho 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licerses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEARI Physician /Medical Due to (or as a consequence of). **Examiner** Conominy ANGGRI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner FBRUATUN be executed burial-transit ATRIAL Due to (or as a consequence of) 68760 by Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No Ö 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DWBTY 300 8 26 MIENDING APRIL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature.

SWITE 34 BACTIMONE MD 2/21-4

30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 0130AM 23 2008 Deborah E. Foster /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months 1 M XX 59 **Director** 214-54-5157 11-20-1948 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County a or 28a-f show the notified at show 1√ Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Items 23a o 2419 Greenmount Avenue Apt #2 21218 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2 years Accounting Life Bridge 27 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Teddy Rose Delores Fountain ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt #2 Balto, MB Vincent Fields-Friend 2419 Greenmount Avenue 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Μt Carmel Cemetery 5-2-2008 Balto, MD 21. Signature of Euripral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic 3 Physician Weeks WAIN resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician. The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X10 1 ☐ Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Deat 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After the remaining the funeral process. Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Danna 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Doratotas,

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, MD 21210 Memorial

32. Registrar's Signature MAY 0 1 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April FriHer 2008 11:30AM **Physician** 26 Lugenie rbara /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Kettle Windsor Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, 02 15 5. Social Security Number **Funeral** Days 1 □ M 2 X F 146.38.8317 Jamaica Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location a or 28a-f show be notified at 10a State 10h County Windsor Mill 1 ☐ Yes 2 No Baltimore. MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21244 Kettle ral", or items 23a Examiner must b Completed by Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify "natural", or 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4or 5+) Elementary/Secondary (0-12) n and Mental Hygiene. Union Administrator 2 years 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Myrtle Laraque tmanuel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son permit. Pages 1 and 2 Department of Health a Important: If item 27 Is Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 80/10/20 Greenmount Crematani injury 22. Name and Address of Facility Vaugno C. Greene Fundral SVCS 21. Signature of Funeral Service Licensee Randallstown MD 21133 8728 Liberty Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years Physician Congestive heart disease or condition resulting in death) /Medical Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequ Examine hy percho as the burial-transit Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetec Completed diverticular abscess 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an autopsy nas COPD certificate 1□ Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours are:
To the Funeral Director: After this or e 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) To the Hospital or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical D0064609 APril 29, 200 29b. Signature and title of certifier 30. Name and addres person who completed cause of death (Item 23a) (Type, Print) Myman Park Drive Baltimore, MD 21211 3100 Freedman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#30, per WR, 0879, 5/17/18 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** 9:10 PM APRIL 2008 LONE GREEN 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE TOWSON RUXTUN MANOR CARE 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 94 Yrs. 1□M 2**□**F Days Hours 111-12-8036 Usual Residence of Decedent Director with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ?7 Is marked other then "neturel", or Items 23e or 28e-f show treumatic event, the Medical Examanar must be institled at Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Blac þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Social Socuri 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mit. Pages 1 and 2 si partment of Health an portent: If item 27 Is I rene Green ove po 21216 20c. Location - City or Town, State 2816 Windsor Ave Himove trienc 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ₩ Burial 2 Cremation 3 Removal from State Kesville, MD Greene Finantsm permit. Page Department of Importent: If any injury or 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee iberty Rd. RandallStrum, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GLIOBLASTOMA MULTIFORME Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown certificate has been signed by rector, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 ₩No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortified 29 2008 D57722 APRIL M.D. 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manor Care Ruxton Leonard Allison . Richardson 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 0 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 25,2008 Hori /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Haven atons VIII Under 1 Year | If Under 24 Hrs imore Home 9. Birthplace (State or Foreign Birthplace Country) MD Date of Birth 7. Age (In rs. last birthday) Social Security Number 6. Sex 1 □ M 2 🖁 F Hours **Funeral** 07730/1960 Months 47 218-80-2057 Director Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10b. County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No CATONSVILLE BALTIMORE MI) Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 701 EDMONSON AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other than OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AGINSKY HARRIET SCHWEIDEL SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a : if item 27 is or other train BALTIMORE, MD 419 SCOTT STREET, STARR GRAFFIOUS / DAUGHTER Baltimore, 20b. Place of Disposition (Name of Assistance) K 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
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any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 04/30/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Malle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform death? 2 No certificate Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 2 No 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1. Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number asueeur

State Registrar 31. Date filed (Month, Day, Year)

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Hackett 4:50 a M Carolann 22/2008 04/ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Park Takoma Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/03/1950 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Country) **Funeral** Days 1 □ M 2X3 F 57 Director 577-68-5114 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Washington DC Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20002 1401 Morse Street NE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Caterer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Robinson Nathaniel Johnson James ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 1401 Morse Street NE Washington, DC 20002 Tracey Robinson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/29/08 Suitland, MD 4 □ Donation 5 □ Other (Specify) Lincoln Mem.Cem. 22. Name and Address of Facilit Ronald Taylor II Funeral Hm. 21. Signature of Funeral Service License 108 West North Ave.Baltimore, MD 21201 Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and Division or Vital Records, P.O. Box 68760. attending physiclan for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ned by the atten detached for u Month Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be det 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No 2□ No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide (Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 To the F the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year) MAY 0 1 2008

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30. Name and address of person who completed cause of death (Item 23a)-(Type, Print)



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene of 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** $a^{\,\text{M}}$ 4-29-2008 6:15 Madeline Hopper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Heartlands of Severna Park Severna Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1 M 2 XF 01-30-1922 86 Director 212-16-6170 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ANo Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 U.S.A. 137 Red Fox Circle Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. ≥ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Trevisono Angela Fratangelo ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 si Department of Health an Important: if item 27 is I any injury or other trau once. 137 Red Fox Circle; Glen Burnie, MD 21061 Mr. Andrew Hopper / son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05-03-2008 Glen Burnie, MD Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation 9 Services 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cani ai Physician ast disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the sequence of the cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine g physician and Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months
1 Yes 2 10 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2No 25. Was case referred to edical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 D 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manuar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death. le Funeral Director; A bletely filled in by the fu death. 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hound to the Fune completely fi Medical (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29b Signature and title of contifier 29c. License number

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

ansthuy M. Mersville MD 21108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** April 10, 12:15 PMM Catherine E. Herman /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Elesy Manor Asst Living 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 29, **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F 100 1908 Director 240-05-2456 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Y Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 4010 Buckingham Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ※No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify: white ≥ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) private industry unk unk seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cedona Balch Leslie Ezra Sigmon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau
once. 4100 N. Charles Street #109 Baltimore, MD Bettie Holmes/daughter 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) ig alur of Funeral Servi 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street esicensee de Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immedia Cause (Final disease or condition resulting in death) CA Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to for es a ponsecuença eff. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifted in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 🗌 Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

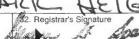
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) MAY 0 1 2008



and manner stated.

person who completed cause of death (Item 23a) (Type, Print

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

License number

29d. Date sighed (Month, Digy, Year)

BUENUE

29b. Signature and title of certified

30. Name and address of

08-03287 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene David Cragg Ickrath 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Physician/ Month Day April 29, 2008 1322 hrs Medical Examiner David Cragg Ickrath 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Phoenix **Baltimore County** 2122 Carroll Mill Road If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Director 06/09/1964 Country) 1 X M 2 KY 220-94-1493 43 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 Yes 2 No 'natural", or items 23a or 28a-f show Examiner must be notified at once. Baltimore Phoenix 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2122 Carroll Mill Road 21131 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12, Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes 1 Yes 2 X No specify: Specify: 3 Widowed If Yes, Give Year White Divorced ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. ant: If item 27 is marked other than "r he Medical Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. 12 Roofer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles R. Ickrath Marie Cragg ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie C. Ickrath 78 Abbeybridge Ct., Lutherville, MD Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) Burial 2 X Cremation 3 Removal from State Department of Important: injury or oth 5/6/08 Donation 5 Other Specify Carrol1 Cremation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road MD 21136 Eline Funeral Home Reisterstown, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line /Medical Death Alcohol and narcotic (heroin) intoxication Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED attending physician AMENDED 27828a-f.perME.g879 5/22/08 TT use as the burial The law requires that the death certificate be Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 ٥ Yes 2 No 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: within 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other 4 Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene FR/Outpatient 3 After this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27 Manner of Death Certification: Natural 1 Yes 2 X No Pending Fnd 4/29/2008 Fnd 12:50 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide

hours after death.
uneral Director: / To the

Medical 29b. Signature and title of certifier Theodore M. King, Jr., MD. fled (Month, Day, Yeer) 08 State

Homicide 29a. Certifier 1

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number DOME O.C.M.E.

29d. Date signed (Month, Day, Year) April 30, 2008

2122 (Arroll Mill Rd. Phoenix, MD

30. Name and address of person who completed cause of death (item 23a)

(Specify)

and manner stated

determined

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 **Physician** 24, Edward J. Jenkins 4:30 AM April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles County Rehab LaPlata Charles If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
May 12, 1 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1XXM 578 52 8614 68 1939 Washington DC Director Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 😿 No Director Pomfret Maryland Charles 10g. Citizen of What Country? th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be n 4405 Lady Trisha Court 20675 United States permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ampl injury or other traumatic event, the Medical Examiner mires once. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. tyTyYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wcrking life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Analyst - CIA 12 Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Joseph Jenkins Lillian M. Underhill ပို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara A. Jenkins (Wife) 4405 Lady Trisha Court, Pomfret, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State Lee Crematory April 25, 2008 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of F) heral Service L/Le 963 Alexandria Ferry Road, Clinton, MD 20735 00 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or beart failure. Immediate C 17 se (Final disease or o dition resulting in death) Approximate Interval Between Onset and Death Physician Failure to Thrive /Medical Due to (or as a consequence of): **Examiner** Malnutriction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Clostridium Diffcile Colitis burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical Severe Debillitation 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. <u>ک</u> 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2\(\Omega\) No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) P this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 (Month, Day Year) 1 🕅 Natural 5 Pending investigation To the river.

Within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier D0061652 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Sindhwani. MD 6 Post Office Road, Suite #101, Waldorf, MD 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State MAY 0 1 Registrar 2008 September 1

Registrar
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32. Registrar's Signature

30. Name and address of persof who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

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Potel M 7501 Surratts Road Suite 307

Clinton, MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2494 **Physician** 6:10 PM 8 005 /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner allstown Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday **Funeral** 1 M 2 F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f show other traumatic event, the Midical Examiner must be notified at 1 ☐Yes 2 No Funeral Director 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Michael Evanina, once. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) y/Secondary (0-12) eyears 18. Mother's Name (First, Middle, Maiden Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as card ic or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** aranoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 2 ER/Outpatient completely filled in by the funeral Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifiei 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H45931 April 3049 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTONSTOWN, MD 25 MAIN STREET Ghorah 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 01 Registrar

DHMH 17 Rev 1/2001

		For State Registrar	State	of Marylar		rtment c tificate				giene- V Reg. No.	00	
Physicia /Medic		1. Decedent's Name (First, Middle, Tadea J. Kowal	Last)		_				2. Date of Dea Month April 3	ath 80, 2008	Year	3. Time of Death 6:15 A. M
Examin		4a. Facility Name (If not institution, Golden Years Manor	give street and n	umber)			vn, or Location imore	n of Death		4c. Coun	ty of Death A	n
Funeral Director		5. Social Security Number 015-05-4798	.Sex 1□M 2▼F	7. Age (<i>In yr</i> s. 87	last birthday) Yrs.	if Under 1 Y Months D	ear if Unde ays Hours	er 24 Hrs. Min.	8. Date of Birth Month, Day August	8, 1920	9. Birth Mass	hplace (State or Foreign untry) Sachusetts
Aaryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10c. Ci	ty, Town or Lo Baltir							10d. Inside City Limits 1 X Yes 2 ☐ No
with the Ita or 28a-	I Director	10e. Street and Number 4607 Kenwood Avenue				10f. Zip Co				10g. Citizen of	f What Co	untry?
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was De Armed F	2 X No live			t of Hispanic (Cuban, Mexic	can, Puerto I	ecify Yes or No- Rican, etc.)	14. Ra	ace - Amer ack, White hify: Whi t	
Maryland 21215-0036 d2 should be filed within 72 hours af th and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Examitralm.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	(Give life. I	ient's Usual C kind of work o DO NOT use r ISTPESS	eccupation lone during m etired)	ost of workii	ng	Garmen		
yland 2 vold be filed Mental Hygi arked other attic event, til	To Be C	17. Father's Name (First, Middle, Li Joseph John Chmura	est)				18. Moi	ther's Name tephan i	(First, Middle, ia Fijal	Maiden Surna	ıme)	
Ma and 2: allth au 127 is 27 is r trau		19a. Informant's Name/Relationship Eleanor Knight/ Exe				-			nore Mary			(ip Code)
altimore, mit. Pages 1 ar partment of Hea portant: If item: y Injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal fror	n State	Place of Dispo cemetery, crei illtop Se	natory or othe	r place)	5/1/	/08	20c. Location	•	
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Physician /Medical Examiner be executed bhysician and the bruial-transit the bruial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a consector of cor ect o	quence of): quence of):	CAF	245 1 Um	Hs w	MR_	DISE	15E	
. Box 6 death certifi e attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic preg					Date of del	livery Day Year		
ds, P.O uires that the signed by the	by	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	nderlying caus	se given in Pa	rt i.	23e. Did t			o the cause of death?
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Sta Registr		31. Date filed (Month, Day, Year) MAY 0 1		Registrar's Sign	Tyre for	whi					,	

Registrar

State

124

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ON

Bell

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31. Date filed (Month, Day, Year) MAY 0 1 2008

Peter. P.

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OWSON

MD

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signatu	re uneral S Rona	Service Licer	Wada.	Directo	r	22. Name State	and Addres	ss of Facility	oard	655	W. B	altim	ore	Street	
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To the within To the comple		ature and title o		and manner	stated.				nse number						nth, Day, Year)	

31. Date filed (Manth, Par) State Registrar

Laron Locke MD

celle 30. Name and address of person who completed cause of death (Item 23a)

T') 2008

DOME

Assistant Medical Examiner

3. Registrar's Signatur

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 4, 2008

	1	State Registrar	Cert	tificate of L	Death	Reg.	No.	
		Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day Year	3. Time of Death
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/Medic Examin	26	Na Facility Name (If not institution, give street and number) Na Thwest Maspital Ceuter		4b. City, Town, or Rundal	Location of Death		Ac. County of Dear	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 12 M 2 F 82	t birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min. 0	Date of Birth (Month, Day, You 2/02/192		thplace (State or Foreign ountry) GA
	t	Usual Residence of Decedent						
ylanc ylanc		10a. State 10b. County 10c. City, 7	Town or Loc	eation				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
Mar a-f sl	형	MD BALTIMORE RAN	NDALLS	TOWN				
in the	jie	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	ountry?
th will	<u>a</u>	3624 TEMPLAR ROAD			21133		USA	
ems ems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 1 Married 1 □ Yes 2 1 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1	□Yes 21X No	Specify:		Specify:	WHITE
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and A	Be	17. Father's Name (First, Middle, Last)	(DICV					VET
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Manual State of the state of th		19a. Informant's Name/Relationship (Type. Print) SHIRLEY KRICK / WIFE	36	24 TEMPL	AR ROAD, R	ANDALLS1	TOWN, MD	21133
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altimor mit. Pages partment of portant: If it y Injury or o		4 □ Donation 5 □ Other (Specify) BETH	1 ISRA	EL	04/30/		BALTIMOR	
Falt ermit. epartu epartu port ny Inj		21. Signature of Funeral Service Licensee	22	. Name and Addre	ss of Facility SOL	LEVINS	ON & BROS	., INC.
n 82 E 8 8		Malt Le			TERSTOWN R			Approximate
		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.					ι,	Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	Ocas.	dial F	ufarction	/		
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death c death c attend	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	death 3□	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year
Vital Records, P.O stolan: The law requires that the certificate has been signed by the rector, page 2 should be detache	ͳ	Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
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Division or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	me, farm, str	reet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
pital purs a leral filled		29a. Certifier 1 Certifying Physician: To the best of my know	viedge, deat	th occurred at the t	ime, date and place, a	and due to the ca	use(s) and manner	as stated.
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orth Nithin Somp	Me	29b. Signature and title of certifier		29c. Licen	se number		d. Date signed (Mo	
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:1		30. Name and address of person who completed cause of death (Item	23a) (Type,			// /		
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Sta Regist	ate rar	30. Name and address of person who ompleted cause of death (Item 5 + 2 0) A X a + 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ure A	we!		,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0 Physician Thelma Lucas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GOOD SAMARÄAN AUSPITAL OF CALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 F Feb. 21,1935 Maryland Director 216-30-9809 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 1 ☐ Yes 2 X No ed other than "natural", or items 23a or 28a-f shevent, the M. dical Examiner must be notified Director Baltimore County Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21224 7515 Belmont Avenue 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: \$ 3altimore, Maryland 21215-003 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Food Service General Motors Corp. 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Anna D. Wilkinson William F. Turnbaugh ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Jachelski (Daughter) 7504 Poplar Ave. Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State IN Burial 2 ☐ Cremation 3 ☐ Removal from State 5/1/2008 Middle River, MD Holly Hill Mem. Gdns. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each inse Approximate Interval Betw Onset and D Onset and Death Immediate Cause (Final disease or condition resulting in death) YLOID ANGIOPATHY Physician /Medical Due to (or as a consequence of): TRACRANEAL HEMORRHAGE Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine HOURS CEREBRAL HERNIATION The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) been signed by the s 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HY PERTENSION, DYSLIPIDEMIA, IRON DEFICIENCY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SETZURE DISORDER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autonsy perforn or Attending Physician: funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0438934881 Good Samaritan Hospital Center 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MACO-FLORES VICENTE 5601 Loch Raven Blvd. Baltimore, MD 21239 32. Regis rar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear Sheila Mogliazt : 24 PM Anita tori 28 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A university of Baltimore Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🔀 Days Months Hours Min. 220-64-5961 51 Aug.1,1956 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1√Yes 2 No N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3315 Menlo Drive 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Self-Employed College (1-4or 5+) Year Elementary/Secondary (0-12) Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leroy Hooker Sylvia James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sabrina D. Owens/Sister 3315 Menlo Drive Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/6/08 King Memorial Park Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris Funeral 5240 Reisterstown Road Baltimore,Md 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac Due to (or as a consequence of) povolemic Hypovolem Lue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sepsis Due to (or as a consequence of): IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Pulmonary Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.2.No Osteomyelitis 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 28a. Date of Injury (Month, Day Year)

Physician /Medical Examiner

Examiner

Physician/Medical

Completed by

Be

P

Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified.

Baltimore, Maryland 21215-0036

sician and burial-trans physician as the for ed by the a has director, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

in the past 12 months? 1 ☐ Yes 2 X No 9 Unknown

ER/Outpatient 3 DOA Other: 4 Nu	rsing Home 5 ☐ Residence 6 ☐ Other (Specify)
28b. Time of Injury 28c. Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ ft	28d. Describe how injury occurred
nome, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

29d. Date signed (Month, Day, Year)

, M.D

28e. Place of injury - At h building, etc. (Spec

22

AU4176435N16686

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Baltimore, MD 21201

Noticewala 31. Date filed (Month, Day, Year) MAY 0 1 2008

32. Registrar's Signature

State Registrar

Physician /Medical Examiner the death certificate be executed as the burial-transi A CE attending physician nse Po signed by the at d be detached for cate has been signated by page 2 should by Attending Physician: director, this in by the funeral al or Attending Plater death. filled Hospital within 24 hours a To the Funeral I completely the

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or dical Examiner must be

the Medical

than

is 1 and 2 should be filed within the Health and Mental Hygiene. Item 27 is marked other than

permit. Pages 1 ar Department of Hea Important: If Item i any injury or othe

Director

Funeral

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

Maryland 10e. St**rey mg** Number 4956 Harrier Court 11. Marital Status 1 Never Married 2 Married þ 3 Widowed 4 Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) Emma Jean Ennis (Daughter) 20a. Method of Disposition

A ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner? Be 1 Tes ဥ 27. Manner of Death Certification: 1 Natural
2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certiffe D0057999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manisha Jariwala, M.D. 11637 Terrace Drive, Waldorf, MD 20603 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State MAY 01 2008 College of Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:10 P^M 2008 26, April Lois Elizabeth McIsaac /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Calvert Prince Frederick Calvert County Nursing Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F 88 178 12 Nov 13, 1919 PA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Calvert Maryland Chesapeake Beach 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with United States 3116 Burgess Road 20732 Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after oal Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TVNo Specify: Completed by White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 4 Placement Officer Federal Governmet 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental Fitem 27 is marked of rother traumatic ever John McIsaac (UNKNOWN) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Miller (Executrix) 3116 Burgess Road, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages t Department of He Important: If iter any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 3, 2008 Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD Jours O Grand m00251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner DATHASION Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 1MIG burial-tran be exec Due to (or as a consequence of): attending physician Physician/Medical the l use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months?

1 Yes 2 No
9 Unknown 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy performed 1 Yes 2 □ certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. al or Attend after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

Box 68760. P.0. Division or Vital Records. To the Hospital c within 24 hours af To the Funeral D

Saltimore, Maryland 21215-0036

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

5801 Allentown Road Suite 500, Camp Springs, MD

Mathur,

31. Date filed (Month, Day, Year) MAY 0 1 2008 00061447

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 0120 M Clain 26 3008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimere Maryland MIL niversity If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 318-78-4984
Usual Residence of Decedent Days 1**X** M 2□ F Director Ba Himore 10d. Inside City Limits death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. State 10b. County 1 Nes 2 No $\mathcal{M}\mathcal{D}$ Director 10g. Citizen of What Country? 10e. Street and Namber USY 21229 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married laltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life OO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer ath other 1 Burial 2 Cremation 4 Dopation 5 Other (3 Removal from State 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physiclan; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🔗 the burial-transit Due to (or as a consequence of) physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Mo 24a. Was an autopsy performed? 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1: Impatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, MAY 0

WD 21201

Diegelmann

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) 1 1 2008 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 04 Day 26 **Physician** 2008 Elmer Merkson 9:40PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis Elder Care Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NV 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 03-03-1929 Days Hours Min 1X M 2□ F 79 Yrs. NY 213-26-1783 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 133 Garrett Road 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or iter any Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chief Caller B & O Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be E. Merkson Ilse Bimba ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Burnie, MD 21061 Ms. Tanya Brown / Daughter 133 Garrett Road 20b. Place of Disposition (Name of cemetery, crematory or other place) May 2 ate 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 2008 Maryland Vets. Cem. Crownsville,MD. 4 Donation 5 Dother (Specify) 22. Name and Address of FacilitySingleton Funeral & Cremation Srv 21. Signature of Funeral Service Licenses 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final with websitche lesiain Budsonin 600 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 | Fetal death 1 ☐Live birth Day Month in the past 12 months? 4□Pregnant at time of death signed by the at d be detached for 1 Tyes 2 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ ★ 3 ☐ Probably 4 ☐ Unknown been si should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed? certificate Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one, 25. Was case referred to medical Be Other: 3□ D0A 1 | Yes 2 | 40 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date, signed (Month, Day, Year) 29c. License number D?436 W me Clarke MS 21619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0

2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 149a M Medicus 2008 (> Kichard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. N/A Maryland Medical Center Diniversity of 5. Social Security Number Birthplace (State or Foreign Country) . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral X**M 2□ F 219-50-0801 60 Yrs. 3-2-1948 Director Maryland Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1√ Yes 2 No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 USA 3505 Keswick Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 white 1 ☐ Yes 2€No Specify þ 3 ☐ Widowed > ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electric Company 12+ Electrician or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is 1 and 2 should be fill Health and Mental H tem 27 is marked oth Wyatt Medicus Marie Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any Injury or other trau 3154 Keswick Road Theresa Medicus Baltimore, MD 21211 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 ☐ Burial 2 🔀 Stremation 4/30/08 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature eral Service Lioens 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Baltimore, MD or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between 23a. Part Enter the disease shock, or heart failure Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia Week /Medical Due to (or as a consequence of): Examiner Week 1 rrhosis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed the burial-trans Due to (or as a consequence of): attending physician use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24a. Was an was an autopsy performed?
Yes 25 No page 2 s has certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

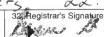
Division or Vital Records, P.O. Box 68760,

State

Adrienne 31. Date filed (Month, Day, Year) MAY 0 Registrar

(Check only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 14264 amend #8 per Inf G880 6/03/Department of Health and Mental Hygiene [] [] [] []

Important: If item 27 is marked other then "netural; or items 23a or 28a-1 ehow and injury or other traumatic event, the Medical Examination in the model of the	Kenneth R 4a. Facility Name (If no 40144 Watters of December 10a. State MD) 10a. State MD 10b. Street and Number 40144 Watters of December 11. Marital Status 1 Never Married 3 Widowed 4 [15] 15 (Specify december 12 17. Father's Name (Fine 19a. Informant's Name 1de Hill/6 20a. Method of Dispos 1 Burial 2 Do	Montez of institution, give erview D ber 6. Se 6.7 1 poedent Ob. County St. Mary erview Dr 2X Marned Divorced Divorced only highest grad any (0-12) st, Middle, Last)	street and number) Prive The street and number of the street and numb	ver in U.S.	Medinhday) Yrs. If Under Months If Under Months In Or Location 10f. Zig 13. Was Dece If Yes, spe 1 Yes Decedent's Usu	chanic ri Year Days 11e c Code 20 dent of Hisp crity Cuban, 2X No	ocation of Death PSVI11e If Under 24 Hrs. Hours Min. 0659 Danic Origin? (Sp. Mexican, Puento Specify:	8. Date of Birth (Month Cay,	9. Citizen of What Black,	Death ry's . Birthplace (State or Fore 111110 is) 10d. Inside City Lim 1 Yes 2
am 27 is marked other then "netural", or items 23a or 28a-1 ehow and ther traumatic event, the Modical Examinar must be notified at the traumatic event, the Modical Examinar must be notified at the traumatic event, the Modical Examinar must be notified at the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the rectified at the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event, the Modical Examinar the traumatic event e	4a. Facility Name (If no. 40144 Watt 5. Social Security Num 344-14-686 Usual Residence of De 10a. State MD 10e. Street and Number 40144 Watter 11. Marital Status 1 Never Married 3 Widowed 4 [15] (Specify Elementary/Seconde 12 17. Father's Name (Fin 19a. Informant's Name Ide Hill/6 20a. Method of Dispos 1 Burial 2 10	erview D continuity St. Mary arview Dr 2\text{Marnied} Divorced Divorced Divorced Divorced Divorced Divorced Any (0-12) st, Middle, Last)	street and number) Orive x 7. Age M 2 F 7. Age Tive 12. Was Decedent E Amed Forces? 1 Yes, Give Year or Dates: (cation le completed)	10c. City, Tow Me ch ver in U.S. 142–64	Medinthday) If Under Months If Under Months In It Under Months In It Under Months It U	chanic ri Year Days 11e c Code 20 dent of Hisp crity Cuban, 2X No	esville If Under 24 Hrs. Hours Min. 0659 Danic Origin? (Sp. Mexican, Puerto	8. Date of Birth (Month Day, Mar 16),	4c. County of St. Ma y1923 9 1	Death ry's . Birthplace (State or Fore 1011110 is) 10d. Inside City Lim 1
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atio	Natural 5 2 ☐ Accident	Pending investigation	(Month, Day	rear)	Injury M	Work? 1 ☐ Ye	s 2□No			
led in by the funera Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	arm, street, factor	y, office		28f. Location (Stre City or Town,	et and Number (State)	or Rural Route Number,
completely filled in by the tr	29a. Certifier	Certifying Phys Medical Exami	sician: To the best of ner. On the basis of e and manner state	examination ar	e, death occurred novor investigation	at the time, , in my opin	date and place, ion, death occur	and due to the cau red at the time, dat	use(s) and manne te and place, and	er as stated. If due to the cause(s)
comp	29b. Signature and title	of certifier			290	c. License n	umber	29	d. Date signed (A	Month, Day, Year)
	1	Matt	~			22f	352		4174	105
	30. Name and address	of person who co	ompleted cause of dea	ath (Item 23a)	(Type, Print)	- 1-	~	1 20	1116	
State		Day, Year)	32. Registrar				- 1 - 1.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 2008 MANDELL 3:20 P JAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON Birthpie Country) MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/26/1943 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 219-42-5264 64 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show nermust be notified at 1 ☐ Yes 2 💢 No Director FL PALM BEACH **BOCA RATON** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7754 LAKESIDE BLVD. 33434 USA Funeral natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR JANITORIAL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MANDELL JOSEPH **ELEANOR** BALLOW ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7754 LAKESIDE BLVD., BOCA RATON, FL HEDY MANDELL / WIFE or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. BETH EL MEMORIAL PARK : 04/30/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licensee SOL LEVINSON & BROS., 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme vate Cause (Final disease or condition resulting in death) FAILURE **Physician** /Medical Examiner - RENAL SYNDROME EPATO Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ward of physician and the burial-transit LIVER TRANSPLANT 2002 Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3

Ectopic pregnancy Day Year 5 ☐ Other (specify) been signed by the a should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DYSPLASTIC SYNORUME 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 □No 1 ☐ Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSFICE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation the 1 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number D64395 APRIL 28,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST, SUITE 209 BALTIMORE MW 21204

State Registrar

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2008

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31. Date filed (Month, Day, Year)

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. Registrar's Signature

DHMH 17 Rev 1/2001

death with the Maryland

Baltimore, Maryland 21215-0036

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P.O. Box 68760,

Division of Vital Records,

Attending Physician;

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Registrar

State

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Avenue Baltimore Manyland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Registrar's Signature

Lynn Tao

31. Date filed (Month, Day, Year) MAY 0 1

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	Funeral				ge (In yrs. last bii		If Under 1 Year Months Days	If Under 24 H	1rs. 8. D	ate of Birth	1912	9. Birthp	lace (State or Foreign
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	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba		(Specify	res or No-	14. Race		
9	after or Ite		1 Never Married 2 Marrie	Armed Forces2 1 ☐ Yes 2 ② If Yes, Give			i Yes, specify Cuba 1 □ Yes 2 X No	Specify:	Jerio nicar	i, etc.)	}	White,	
8	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:							Specify:	Whi	.te
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or Items 23s or 28s-f show event, the Medical Example in the political event.	Completed by	Elementary/Secondary (0-12)	College (1-4or			emaker	,			Own	Home	2
d 2	filed Hygin ther ant,		17. Father's Name (First, Middle, La	st)				18. Mother's 1	Name (Firs	t, Middle, N	faiden Sumame		
an	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be	Earl Ross Gaitl	ner				Annie	Eassa	lear	Smith		
2	shound M	-	19a. Informant's Name/Relationshi	(Type, Print)	198	o. Mailir	g Address (Street a					tate, Zip	Code)
Ž			Walter C. Peter	son,Jr.	28	304	Louise A	venue B	Baltin	nore,	Marylan	d 21	.214
ē,	of Heri	1	20a. Method of Disposition		20b. Place o	of Dispo	sition (Name of natory or other plac	e)	Date	2	20c. Location - C	ity or To	wn, State
Ē	Pages nent of int: If it iry or o		1 ☐ Burial 2 ⚠ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				matory I		/28/0)8	Baltimo	re,	Maryland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other trongs.		21. Signature of Funeral Service Iti	censee	1800	4 €	remation 99 Frede	sStelet	y Of	Maryl	and, In	c.	
<u> </u>	Depident Dep		Thomas Gregor	:0								ylar	d 21228
Н			23a. Part1. Enter the disease, or c shock, or heart failure. List or	emplications that cause ily one cause on each li	d the death. Do ine.	not ent	er the mode of dying	g, such as card	diac or res	piratory arre	st,		Approximate Interval Between
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89	g physicate as the b	edical											
Вох	death cert e ettending ed for use a	N/C	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death		Ectopic pregnancy				23d. Date	of delive	ery
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	se in ed	۵	Part II. Other significant condition	s contributing to death t	out not resulting i	n the u	iderlying cause give	en in Part I.	,				ne cause of death?
orc	v require been si should t	eted							-	1 🗆 Ye		- F100	ably 4 Unknown
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Ö	al or A s after of in b	Certification:	4 Homicide	building, et	tc. (Specify)				(City or Town	, State)		
	Hospital or Attending 24 hours after death. Funerel Director: After tely filled in by the fune		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best aminer: On the basis of	of my knowledge	e, death	occurred at the tim	ne, date and pla	ace, and d	ue to the ca	use(s) and man	ner as st	ated.
	To the Hos within 24 hr To the Fun completely	Medical	one)	and manner st	ated.				ocurred at				
	5 × 5 00	*	29b. Signature and title of certifier	700 a A			29c. License				od. Date signed		
	_		Dr. Bahelee V	in grey	AT TO			13657			prel 28	de	28
_			30. Name and address of person w	GREGOR, 7	00 W. 4	-0 4C	STREET,	BALTI	DORE	600 /	21211		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 1 2	Registr	rar's Signature	Con	de la						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 5.00 aum וחמל 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frankford Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. 219-22-1119 85 4-19-1923 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location XXYes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5709 Chinquapin Parkway 21239 Ū S Α Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes ŽŽŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Homes llth grade N/A Domestic Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Wesley Powell Rose Marie Powell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5709 Chinquapin Baltimore, MD 21239 Peggy V. Powell-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 5-2-2008 |Randallstown, MD March F/H 22. Name and Address of Facility 21. Signature of Fungral Service Licensee 1101 E. North Avenue Balto, MD 21202 Lm caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final LUNG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregna 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☐ Yes 2 No 1∏ Yes 2VNo 25. Was case referred to medical examiner?
12 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury 27. Man r of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director; 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26 08 who completed cause of death (Item 23a) (Type, Print)

WAS PACE -30. Name and address of person 8813 32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 29, 2008 6:20P M Melvin Monroe Pumphrey April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 6509 Clear Drop Way Unit 102 Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept.9,1922 Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months MD 218-12-8126 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6509 Clear Drop Way Unit 102 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 (M) No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 M Married Specify: White 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15/ Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Belt Pumphrey Ida Franklin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6509 Clear Drop Way Unit 102 Glen Burnie, MD 21060 Mrs. Dorothy Pumphrey/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 T Cremation 3 ☐Removal from State 2008 Stevensville, MD. 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation 22. Name and Address of Facility Singleton Funeral & Cremation of Funeral Service Licenses Services 1 2nd Avenue SW Glen Burnie, MD 21061 2 a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mO(f)Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, A. Il or Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2No 3 Probably 4 □Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an After this certificate 1 Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🗍 Inpatient Certification: To funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? (Month, Dav Year) Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) title of certifier 29b. Signature fitem 23a) (Type, Print 10s Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month Day PRIBISH **Physician** MARI :54PM APRIL 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL RANDAUSTOWN BALTIMORE NORTHWEST | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 10, 1914 9. Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 93 Director 172-12-6362 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 No Director MD Baltimore Owings Mills 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must b 21117 USA 115 Cedarmere Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify Specify þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event *hea Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John Lisko Bertha Bodak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Sofranko Daughter 115 Cedarmere Road, Owings Mills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/1/08 4 □ Donation 5 □ Other (Specify) Carroll Cremation Hampstead, MD 22. Name and Address of Facility 21. SignatOre of Funeral Service Licensee 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death larmediate Cause (Final disease or condition resulting in death) CARDIOVASCULAR **Physician** ATHEROSCLEROTIL /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 V No 3 □ DOA 1 Inpatient 2 ER/Outpatient ၉ 28a. Date of Injury (Month, Day Year) 27. Mar ner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: 24 hours a e Funeral I the

Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COVET (LOAD) 5401 MICHAEL Q OTHKIN OUD Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 1 2008

Description Description			-	For State Registrar	State	of Marylar		artment of I rtificate of				giene Reg. No.	4 U U O	14271
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Physician (Medical Examiner) Sequentially accordions, if any, leading to medical disease or coordinate flat conditions, if any, leading to medical disease or coordinate flat conditions, if any, leading to medical conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, if any, leading to mineral are conditions, and the past 12 moghles? Due to (or as a consequence of): Due to (or as a consequence o				23a, Part 1, Enter the disease, or co	omplications that	caused the deat							CALLYLO	
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25. Was case referred to medical examiner? 26. Place of Death (Check only one) Continue of Death Co	that	deta		Part II. Other significant condition	s contributing to	death but not res	sulting in the u	nderlying cause gi	ven in Part	l.	23e. Did to	obacco (use contribute to	the cause of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 Day APR#L 2258/M Evelyn Dorothy Rosenberger 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore FRANKLIN Square Hospital Center Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 1, 1916 9. Birthplace (State or Foreign 5. Social Security Number Hours Min. 1 □ M 2 T F Mary land 216-03-1533 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 8820 Walther Blvd. Apt. 4305 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phillip Smith Elizabeth Whitehead 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edmund J.V. Rosenberger, Son 1032 Saxon Hill Drive Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 04/30/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Hemorrhage Intracranial Due to (or as a consequence of): tall Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.

Completed by

Certification: To

Division or Vital Records, P.O. Box 68760,

Department of Health and Mental Hygie Important: If Item 27 Is marked other i any Injury or other traumatic event, <u>tr</u> once.

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show ner must be notified at

Funeral

þ

Completed

Be (

with the Maryland

72 hours after

Maryland 21215-0036

Baltimore,

Rosenberger

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

1 √Yes 2 No 27. Manner of Death

5 Pending investigation

MAY 0 1 2008

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 No 28d. Describe how injury occurred

Baltimore

fall

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide 4 Homicide Apr: 122,2808 unknow M 1 228e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28e. Place of injury - At home, farm, street, factory, office determined

28f. Location (Street and Number or Bural Foute Number)

City or Town, State) 38 2 2 3 9

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIN Square DR DR Aday Behari

32 Registrar's Signature

State Registrar

Physic	ian	1- State Registrar 1. Decedent's Name (First, Middle, Last)	Octimicate of Death	2. Date of Death	Day Year	3. Time of Death
/Med Exami	cal	Aa. Facility Name (If not institution, give street and number) RIDGEWAY MANOR NURSING HOME	4b. City, Town, or Location of Death CATONSVILLE	APRI	4c. County of Deal BALTIMORI	th
Funeral Director		5. Social Security Number 212-80-6543	oirthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 08/19/	1923 9. Bin	hplace (State or Foreigr puntry) RYLAND
ne Maryland 8a-f show	Director	MARYLAND ANNE ARUNDEL	wn or Location GLEN BURNIE			10d. Inside City Limits 1 ☐ Yes 2 → No
h with ti		10e. Street and Number 6666 ROBERTS COURT	10f. Zip Code 21061		0g. Citizen of What Co JNITED STAT	
5-0036 72 hours after death with the Maryland neturel; or Items 23s or 28s-1 show diesi Exertin wr mat be redified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forcecty 1 Yes 2 Pholif Yes, Give If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: WF	
in 72 hours in 72 hours n "neturel",	Completed	(Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business/	Industry
1212 led with ygiene. her ther	Comp		OUSEKEEPER		CLEANING S	SERVICES
land Id be fil Idental H Red oth	To Be	17. Father's Name (First, Middle, Last) JESSIE CURTIS	18. Mother's Nam-	e (First, Middle, N A PETERS		
Mary 12 shound he and he resumes			Pb. Mailing Address (Street and Number or Run			Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours all Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel, or enty injury or other treumatic event, the Medical Exert once.		20a. Method of Disposition 20b. Place cemet	2901 PINEWICK RD. ELL of Disposition (Name of ery, crematory or other place) HAVEN MEM. PK.	Date 2	20c. Location - City or	.042 Town, State E, MARYLANI
Baltin permit. I Departm Importar eny injur		21. Signatur of Funeral Service Licensee	KARTEN ARUBUTEK FUN 421 CRAIN HWY. S.E.			
Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one fause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions,		or respiratory arre	est,	Approximate Interval Between Onset and Death Mently
68760, X tificate be executed g physician and as the burial-transit	Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mitiated events resulting in death) Last Due to (or as a consequence of the consequence o			11	
BOX death cert e attending for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of del Month	ivery Day Year
- 5 D D	by	Part II, Other significant conditions contributing to death but not resulting C9 Chexis	in the underlying cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pr	
The taw ate has b	Completed			24a. Was an autopsy perform	/ prior to d	topsy findings available completion of cause of
E fe en	To Be				nce 6 Other (Spec	cify)
Division To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
ne Hospi ne Funer pletely fill	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination and manner stated.	pe, death occurred at the time, date and place, nd/or investigation, in my opinion, death occurr	and due to the car ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To ti To ti	M	29b. Signature and title of certifier After Aft	29c. License number D36942	29	d. Date signed (Montl) April 27	1, Day, Year)
1		30. Name and address of person who completed cause of death (Item 23a)	1 D36942 Frederick Rd. G	tong uil	1/c, mo ?	2,228
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	nete			

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State Registrar

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Funeral	5	Social Security Number 6. Se		e (In yrs. last bi	rthday) If Uni	der 1 Year ths Days	If Under 24Hr Hours Mir		The OI BITTITION	110/UU/11	Foreign	Intry)MAQUS &I
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rylan rylan st onc	홠	10e. Street and Number	//1		10f. Z	ip Code	.////////	<u>\</u>	10g.	Gitizen o	f What Coun	try?
within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f show any Medical Examiner must be notified at once.	Director 7	5719 HIC	HGAT	F NRI	VE	C	2121	5			USA	
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r iten	Funeral	1 X Never Married 2 Married	Armed Forces	X No				to racan,	etc.)		2	I A A IV
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Box 68760, e death certificate be the attending physic ed for use as the but	sic	1 Yes 2 No 9 Unknow		at time or doutr	5 Other (S	Specify)						
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Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been siled in by the funeral director, page 2 should the fine or the control of the funeral director.		25. Was case referred to medical				26.Plac	e of Death (Che	eck only				
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No.		30. Name and address of person wh			3a) * - 111 Donn S:	troot Po	Itimore MD	21201	l			

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State

Registrar

31. Date filed (Month, Day, Year)

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istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** April 21, Emily F. Reahl 12:25 AMM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charlestown Retirement Center Baltimore Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 17, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖸 F 212-44-2200 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 1 ☐Yes 2 No MD Baltimore Catonsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 713 Maiden Choice Lane 21228 USA Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If them 27 is marked other them any Injury or other traumation. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: white Specify: 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur K. Austin Carolyn Mace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Scott Patterson/grandson 36 Broad Bridge Road Baltimore, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) . Wade, 22. Name and Address of Facility 21. Signatur, of Funeral Service lice State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. shock Immediate suse (Final disease or condition resulting in death) amentla Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) ihe th 9 Unknown 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 20 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending investigation n 24 hours after death.

The Funeral Director: Af oletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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	1 For	State of Marylar		artment of H rtificate of I				14211
	Registrar 1. Decedent's Name (First, Middle, L	ast)	06	Tillicate of t	Death	2. Date of Dea	eg. No. th	3. Time of Death
Physician /Medical	Genevera E	stelle Robins	on			April :	28, 2008 Year	8:10 A ^M
Examiner	The same are the same and the same are	ve street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	ath
	Southern Mary1		(Clin	ton If Under 24 Hrs.	8. Date of Birth	Prince G	
Funeral Director	5. Social Security Number 6. 579 14 2711	Sex 7. Age (In yrs. 1	Yrs.	Months Days	Hours Min.	(Month, Day	, Year) 2. 1914 M	rthplace (State or Foreign ountry)
	Usual Residence of Decedent					rigi cii		10d. Inside City Limits
arylar show	10a. State 10b. County	10c. C	ity, Town or Lo					1 Yes 2 No
vith the Mark or 28a-fe	MD P.G.		Fort '	Washingto	<u>n</u>	1	log. Citizen of What C	X
with the same of t	6701 Farme	r Drive		2074	4		United S	
r tems 23a	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H		ecify Yes or No-		erican Indian,
urs after	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes, Give X X If Yes, Give X X Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	Thousi, occ.,	Specify:	White
72 hou	15. Decedent's (Specify only highest of		16a. Dece	edent's Usual Occup	ation during most of work	rina	16b. Kind of Busines	
ed within 72 hor ygiene. The Malcall	Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of work done DO NOT use retired		9	110 01 1	6.0
Hygie other t		st)	AC	counting		e (First, Middle,	US Chambe Maiden Sumame)	rs of Comerac
Mental Mental mrked o atic eve	9				Henr	itta Ma	ae Acton	
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Pages 1 ent of H nt: ff ite ry or oth	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Musilian State		osition <i>(Name of</i> Imatory or other plac Hill Maus	- 1		20c. Location - City o	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23e or 28e-f ehow important: if item 27 is marked other then "natural", or items 23e or 28e-f ehow may injury or other traumatic event, the Madical Exemplar maral be notified at 2002. To Re Completed by Funeral Director	21. Signatur 1 Fineral Lice Lice		1 2	2. Name and Addre	ss of Facility Lee	Funera	1 Home,Inc	6633 Old
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/Medical Examiner	resulting in death)	Due to (or as a conse	quence of):	0,110				
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death certifications at the death of the transfer as a standard of	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	tal death 3	□Ectopic pregnanc □ Other (specify) _	y 		Month	Day Year
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ysician: The is certificate director, pag	25. Was case referred to medical	<u></u>			26. Place of Dea			
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L ge different	27. Manner of Death Natural 5 Pending Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ryat rk? Yes 2∐No	28d. Describe n	low injury occurred	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 9 per fh/8879 5-2-08vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month RUPPEL JOHN **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) Feb. 9, 1921 BALTIMORE, MD BON SECOUNS HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1**√**32M 2□ F 87 212-12-4270 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State "naturai", or items 23a or 28a-f show edical Examiner must be notified at 1 ☑ Yes 2 ☐ No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 USA 1217 West Fayette Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1xxNever Married 2 ☐ Married Specify: White 1 ☐ Yes 2XXNo 3altimore, Maryland 21215-0036 by 3 Widowed 4 Divorced 16b. Kind of Business/Industry unk Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ımk College (1-4or 5+) Elementary/Secondary (0-12) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 S. Calvert Street; Baltimore, Maryland 21202 Cassandra Lucas / Guardian 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/01/2008 Mount Zion Cemetery Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. FIRSTS Approximate Interval Between Onset and Death Physician /Medical ASPINATION DUE UNIONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner EXACER BATIDAL Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HYPERTENSION; CONONARY ARTERY DISTAGE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown SEITURE; HYPOTHYROID; ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? SCHIZO PHRENIA: ATRIAL FIBRILLATION 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, and title of certifier 4/27/2008 D149 49 mogribeli, m.o 2000 W. BALTIMORE STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANET V. MOGHBELLI, MD BALTIMURE, MD 31833 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 1 2008 **Physician** 3°0° 3:10 A M Margaret Irene Reynolds /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist If Under 1 Year 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) 01-25-1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Min. Months Days Hours 1 □ M 2 🖔 F 88 212-05-2721 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Actical Examinor must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Lutherville Baltimore 1 ☐ Yes 2 X No Director 10f. Zip Code 21093 10g. Citizen of What Country? 10e. Street and Number 616 Goucher Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕱 No Specify: Specify: Completed by 3 K Widowed 4 □ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hanson Nathan Franklin Esther Irene Hooper မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Carolyn Abey / Daughter 585 Blue Jay Dr., Golden, CO 80401 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other trong. 20b. Place of Disposition (Name of Durantery Crematory prother place) 20c. Location - City or Town, State 20a. Method of Disposition Date 05-03-2008 Timonium, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens 4 Donation 5 Dother (Specify) 21. Signature $^{22.\,\text{Name and Address of Facility}}Ruck$ Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 2120423a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MANY month ugen 100 disease or condition resulting in death) /Medical Due to (or as a consequence of): month Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine aw requires that the death certificate be execute Decades Vocat Drior COY burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown ed by t signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Hospital or Attending Physician: The director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury ithin 24 hours after death.

the Funeral Director: After the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 100 100 ww 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 21204 6701 MC Day, Date filed (Month, Year) 32. Registrar's Signature State 1 2008 Registrar

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25. Was case referred to medical examiner?		the a	ysic	1 ☐ Yes 2 🗖 🕅 O		at time of death	5	」Other (sp	ecity)							
25. Was case referred to medical examiner?		that the	Ph		s contributing to death	but not resulting	in the u	nderlying c	ause cive	n in Part	l.	23e. Did to	bacco use co	ontribute to	the cause of c	death?
25. Was case referred to medical examiner?	ds,	signe d be	1 by	,			,	,	3			1 520	′es 2□No	3 □ Pr	obabiy 4 🗀 l	Unknown
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25. Was case referred to medical examiner?	3ec	e law has l	id m									autor	sv	prior to d	topsy findings completion of c	available ause of
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The state of Description of Death 1	V.	ician certif ecto	00	examiner?	Hospital:				Othe			The state of the s				
1 Month, Day Year) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and m	of	Phys this al din	H		1 🗆 Inpat				A	415/01					cify)	
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 4-23-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 2c E. Timenium rd #209 Timenium, MD 21093	no	ffei ffei	ion	1 Natural 5 Pending		ay Year)		- 1	Work	?		Lou. Describe i	low injury occ	uiseu		
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 4-23-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 2c E. Timenium rd #209 Timenium, MD 21093	isi	death death stor: / the	Icat	3 ☐ Suicide 6 ☐ Could n	ot be aga Place of It	niury - At home	farm str			03 2		28f Location /	Street and Nu	mher or Ru	ıral Route Num	nher
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 2c E. Timenium rd #209 Timenium, MD 21093	_	spital lours neral filled	Ö	29a. Certifier 1 MCertifying	Physicien: To the bes	t of my knowlede	ge, death	n occurred	at the time	e, date ar	nd place, a	and due to the	cause(s) and	manner as	stated.	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 2c E. Timenium rd #209 Timenium, MD 21093		To th Withir To th comp	M	29b. Signature and title of certified	/	200)						-			
Cyrus Asadi, 20 E. Timenium rel #209 limenium, MD 21093				In A	ret	e	0	1	100	54	420	1	4-2	23-	38	
	-			30. Name and address of person v	no completed cause of	death (Item 23a	ı) (Type,	Print)						0 0	1-0-	
State Registrar MAY (1 1 2008 Registrar's Signature	-								~cl #	\$209	ler	nenice	m, M	110	1075	
THE R. P. LEWIS CO., LANSING, MICH. 490, LANSING, MICH.					Regis	trar's Signature	Son	de								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 2354 PM **Physician** AFRIL 2003 JOSEPH RODOWSKI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BAYNEW MEDICAL CENTER BALTIMORE SOHNS HOPLINS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, Age (In yrs. last birthday 5. Social Security Number **Funeral** Days Hours 1 □XM 2 □ F 52 AUG. 8,1955 213-70-2864 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐Yes 2 No Director BALTIMORE DUNDALK MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 3701 NORTH POINT RD LOT 79 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STOVE MANUFACTURER MACHINIST MECHANIC 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RITA DORN LOUIS S. RODOWSKI ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3912 MISTY VIEW RD BALTIMORE, MD 21220 LOUIS RODOWSKI-BROTHER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/08 BALTIMORE, MD **METRO** 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licenses BALTIMORE, MD 21206 6415 BELAIR RD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or mplica shock, or heart failure. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final HASCUD years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease o, injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed bunial-tran and Due to (or as a consequence of): Box 68760. Physician/Medical as the t asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month for in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an his certificate has by I director, page 2 sh autopsy performed? Yes 2 1 No 1□ Yes Division or Vital 25. Was case referred to medical examiner?
1 ▼Yes 2 No 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death After t Injury (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) MAY 0 1

2008

32 Registrar's Signature

			For State	State of	of Marylan		rtment of F tificate of		Mental Hy	gien Reg. N	0000	11282
			Registrar 1. Decedent's Name (First, Middle, La	st)			- Inouto or		2. Date of De	eath		3. Time of Death
	Physicia		Lila Fay Saul	,					April		ay Year 29, 2008	8:00 P M
*	/Medic Examin		4a. Facility Name (If not institution, giv	e street and nu	mber)		4b. City, Town, o	or Location of Dea			c. County of Death	
		•	3744 Beech Aver	nue			Balti				N/A	
	Funeral		Social Security Number 6. S		7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth av, Yea	9. Birth	place (State or Foreign intry)
	Director		227-40-0555		7:	1 Yrs.			Sept 2	.0,	1936 Virg	ginia
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Mary -f sho	ţo	Maryland N/A			Balt	imore					1 XYes 2 No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What Cou	intry?
	th with	a D	3744 Beech Avenue					1211			USA	
	ems	Funeral I	11. Marital Status	Armed F	edent Ever in U.: orces?	S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0-	14. Race - Amer Black, White	
0	s afte	by Fi	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes If Yes, G	2 ∑ No ive		I⊡Yes 2X∏No	Specify:			Specify: Wh	ite
3	hour:	ed b	15. Decedent's E	Year or I	Jales:	16a, Dece	dent's Usual Occu	pation		16b.	Kind of Business/I	ndustry
2	in 72 n "na Nettic	plet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed,		(Give life.	kind of work done DO NOT use retire	during most of w	orking			
7	d with giene	Completed	Elementary/Secondary (0-12)	College	1-4or 5+)	Leg	al Secre				Law Firm	
2	be filed within 72 hours after death with the Maryland Hygiene. do other than "natural", or Items 23a or 28a-f show event, Ite Marical Examination must be notified at	Be (17. Father's Name (First, Middle, Last						ame (First, Middle a Iresor		en Surname)	
<u>8</u>	Ment Ment arked aric e	으	Willie T. Drape	r				<u> </u>				
<u></u>	2 sho		19a. Informant's Name/Relationship Arthur L. Saul,		nd.						y or Town, State, Z	
≤ D	l and Fealth		20a. Method of Disposition	nusbai		1			Date Date	_	yland 212 Location - City or 1	
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I have a second successively and Injury or other traumatic event, the Medical Examination with be notified at once.		1 ☐ Burial 2 🛣 Cremation 3 🗆		State		sition (Name of natory or other pla		30/08			Maryland
allillo	it. Partme		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice	-	Met		matory I					
Ö	Impo any l		Thomas Gregor	Y		2	remation 99 Frede	Society rick Roa	d Baltin	nore	d, Inc. , Marylaı	nd 21228
			23a. Part 1. Enter the disease, or con	plications that	caused the deat							Approximate Interval Between
w.	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on	0	. (9000					Onset and Death
	/Medical		disease or condition resulting in death) a. ANCET C Due to (or as a consequence of):									13
***************************************	Examiner		Sequentially list conditions	b								
	pi ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):						
	and and I-trans	хаш	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
0/00,	ficate be executed physician and s the burial-transit	a E										
00	ficate phys the	edical		d								
ZOZ	w requires that the death certifices been signed by the attending is should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		76				23d. Date of del	ivery
Ď	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pre	e birth 2□Feta gnant at time of o		☐ Ectopic pregnan ☐ Other <i>(specify)</i> .				Month	Day Year
). O	tt the by the tache	hys	9 ☐ Unknown	9 🗆 Uni							l	
ກົ	es tha igned oe de	by P	Part II. Other significant conditions	contributing to	death but not res	ulting in the u	nderlying cause g	iven in Part I.			10/	the cause of death?
ecords,	equir								- 1	Yes	No 3□Pr	obably 4 Officiowi
Š	e law r has bo je 2 sh	Completed							24a. Wa	opsy	prior to	itopsy findings available completion of cause of
<u> </u>	: The cate his	ပ္ပ							1 □ Yes	formed 2 🔼	? death? No 1 ☐ Yes	2 🗆 No
N Ea	ding Physician: After this certific funeral director,	Be	25. Was case referred to medical examiner?	Hospital: , _			O1	ther:	eath (Check only			
5	Phys rthis ral dii	1.70	1 ☐ Yes 2 No 27. Manner of Death	28a. Dat	Inpatient 2 e of Injury	28b. Time o	III 3 DOA	4 🗆 Nursing			6 □Other (Spe	cify)
Sion	ding th. the fune	tion	1 Natural 5 Pending 2 Accident investigation	(Mo	nth, Day, Year)	Injury		orḱ? ⊒Yes 2 ⊒No				
S	Atter r dear sctor	fica	3 Suicide 6 Could not I		e of Injury - At h	ome, farm, st	reet, factory, office		28f. Location City or T	(Street	and Number or Ri	ural Route Number,
2	al or s afte al Dire	Certification: To	4 ☐ Homicide determined	Duli	ullig, etc. (<i>opeci</i>	197			City of 1	0 W 11, Ot		
	ospit hour unera		29a. Certifier 1 CertifyIng F	hysician: To the	ne best of my kno	owledge, dea	th occurred at the	time, date and pl	ace, and due to th	ne caus e, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one)		nner stated.			nse number				
	5 4 with	2	29b. Signature and title of certifier					38709		290.	Date signed (Mont	7.
						- 005) (**		701-1			913313	0
	10		30. Name and address of person who		use of death (Ite	C .1		#415	(iten!	10	Mid ZI	Z 9C
	1		31. Date filed (Month, Day, Year)		Registrar's Signa		, 67	1, 1, ,	1			1

Registrar

MAY 0 1 2008 322 Hegistrar's Signature



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t in Black Indelible Ink. Ensure All Copies Are Legible. Please Type or yland / Department of Health and Mental Certificate of Death Reg. No 1- For State 3. Time of Death Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Month Da April 7, 2008 Physician/ 1942 hrs Medical Examiner Leroy Spencer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore City** 2009 Guilford Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number unk6. Sex Country) **Funeral** Min Hours Days 1953 54 Aug 4, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Y Yes 2 No Baltimore MT 28a-f shov notified at once. 10g. Citizen of What Country? Directo 10f. Zip Code 10e. Street and Number 21202 IISA 301 N. High Street items 23a or 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. unk marked other than "natural", or items event, the Medical Examiner must be Armed Forces' 2 Married 1 Never Married No Yes 9 Specify black 1 Yes 2 X No specify: If Yes, Give Year Divorced Widowed 16a. Decedent's Usual Occupation (Give kind of work done unit 16b. Kind of Business/Industry "natural" ģ unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 721 Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within: Department of Health and Mental Hygjene. Important: If item 27 is marked other that injury or other traumatic event, the Medica unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Penn Street Baltimore, 20c. Location - City or Town, State O.C.M.E 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2. Name and Address of Facility tate Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 in state Donation 5 X Other Specify: ervice License 21. Sign ture ade Director Konaid Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failur. List only one cause on each line. Death /Medical a Smoke Inhalation and Thermal Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): iner if any, leading to immediate cause. Enter Underlying Cause Exam (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and x AMENDED 23a, 27, 28a-f per ME g879 5/2/08 amh 27 per me g884 10-24-08 vt cal X UNPENDED signed by the attending physician I be detached for use as the burial Physician/Medi The law requires that the death certificate be 23d Date of delivery of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Vunknown Completed by 24b. Were autopsy findings available 24a. Was an s certificate has been si rector, page 2 should b prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Division of Vital Popital or Attending Physician: 25. Was case referred to medical funeral director, Be Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: 1 Inpatient 2 DOA FR/Outpatient 3 1 V Yes No After this ဥ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Yes 2 X No Natural <u>Victim of Dwelling Fire</u> Pending Director: A 4/7/08 Unk 28f. Location (Street and Number or Rural Route Number, City Investigation 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. completely filled in by or Town, State)
301 N High Street, Baltimore, MD Could not be Suicide within 24 hours at To the Funeral D determined (Specify) Vacant Building the Hospital 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 (Check only one) 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 8, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month) Registrar's Signature State 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 29d per dr., 28/9,05/01/08dhb
Reg. No. 1 For State Registrar Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Lyn RUMWA 200 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN 8. Date of Birth (Month, Day, Year) 03/21/1916 9. Birthplace Country) If Under 1 Year | If Under 24 Hrs. (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1□M 201 F 215-10-7217 92 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7211 BROOK CREST WAY, # B3 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COSMETICS BUYER DEPARTMENT STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SIMON SCHULTZ LENA BLUMBERG 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD MADOLA CIDIMUATED / DAUGUTED 7011 BBOOK CRECT MAY #DO 21208 cation - City or Town, State TIMORE & BROS., INC. ESVILLE, MD 21208 Approximate Interval Between Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

April 27, 2008

28d. Describe how injury occurred

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

<u>≽</u>

Completed

Be

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Funeral

Director

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercitizet must be useful of a once.

attending physician and for use as the burial-tran

signed by the a d be detached f

cate has been signage 2 should b

certificate funeral director,

this

After 1

within 24 hours after death

To the Funeral Director:
completely filled in by the

To the h

Medical

State

Registrar

Hospital or Attending Physiclan: The law requires that the death certificate be ex Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical Be Completed by Certification: To 27. Manner of Death

1 Natural
2 Accident

3 Suicide

29a, Certifier (Check only one)

4 Homicide

29b. Signature and title of cer

30. Name and address

31. Date filed (Month, Day,

5 Pending investigation

6 Could not be

a

MAY 01

2008

MAKCIA SIKUMWAIE	IK / DAUGHIEK	1211 DROOK CREST	WAI, #DJ, DF	ALTIMORE, MD 21206			
20a. Method of Disposition	20b. Place	of Disposition (Name of ery, crematory or other place)	Date	20c. Location - City or Town, State			
1 MBurial 2 Cremation 3 Removal from State RETH TETLOH CONG 104/29/2008 RAITIMORE							
4 □ Donation 5 □ Other (Speci	^(y)	22. Name and Address of Fa					
21. Signature of Funeral Service Lice	Bugar			NSON & BROS., INC. PIKESVILLE, MD 21208			
23a. Part 1. Enter the disease, or com shock, or heart failure. List only							
Immediate Cause (Final disease or condition	- Cerebra Thrombosis						
resulting in death)	Due to (or as a consequence						
Sequentially list conditions	b						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):					
that initiated events	c						
resulting in death) Last	Due to (or as a consequence of):						
•	d						
IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery			
23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal dea		Month Day Year				
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown						
Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Pa	art I. 23e. Did to	bacco use contribute to the cause of death?			
			1 □ Y	es 2 □ No 3 □ Probably 4 ☑ Unkno			
			24a. Was a	an 24b. Were autopsy findings availa			
			autop: perfor	med? death?			
			1 □ Yes	2 No 1 Yes 2 No			
25. Was case referred to medical examiner?	Hospital:	26. P	lace of Death (Check only or	HASPICE AT NW			
1 Yes 2 No	1 Inpatient 2 ER/6	Outpatient 3 DOA Other 4 D	Nursing Home 5 Resid	fence 6 Other (Specify)			

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Louis William Stepney, Jr. /Medical 4a. Facility Name (If not institution, give street and number, City, Town, or Location of Death 4c. County of Death Examiner altimore tal N/A Grenera 8. Date of Birth (Month, Day, Year) Mar. 5,1955 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **3** M 2 □ F Months Days Hours Min. Maryland 218-64-0166 53 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show a or 28a-f show t be notified at Baltimore N/A Maryland M Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21202 910 St. Paul Street "natural", or items 23a **Examiner** must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Specify:Black 1 X Never Married 2 Married 1 ☐ Yes X☐ No Specify: þ 3 Widowed 4 Divorced Maryland 21215-00 Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Maaonce. Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Private Residence Nurse 18. Mother's Name (First, Middle, Maiden Surname) Carrie Brown 17. Father's Name (First, Middle, Last) Be Louis W. Stepney, Sr. 19a. Informant's Name/Relationship (Type. Print) Louis W. Stepney, Sr./Father 600 Light Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Mo Baltimore,Md 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Baltimore, Maryland Greenmount Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Foreral Ser 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) piratory **Physician** /Medical Due to (or as a consequence of): Examiner Shoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner neumonia oiration burial-trar and Due to (or as a consequence of): Box 68760 physician pe Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a ld be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but ngt resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page performe certificate 2 \(\text{No} \) or Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after To the Hospital o within 24 hours aff To the Funeral 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

saad 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

M.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

land General Hospital

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 220 PM 2008 Kenneth Alan Summers Abril /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 34 Baltimure HOSPITAL 8. Date of Birth (Month, Day Yea NOV • 26, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 5^{Year)}1942 65 215-40-8811 1 XM 2 □ F Mary land Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examples. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Maryland Baltimore Director Halethorpe 10f. Zip Code 21227 10g. Citizen of What Country? 10e_Street and Number 5234 Arbutus Ave. **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 No White Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Computer Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis E. Summers Emma R. Smallwood ည 19a Informant's Name/Relationship (Type. Print)
Marie E. Mox, personal representative 5234 Arbutus Ave. Halethorpe, MD. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)

West Arundle Crematory 5/1/2008 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Odenton, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus, MD.

23a. Part. Enter the disease, or complications that caused the deathshock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or s a consequence of): 3 year disease or condition resulting in death) Heart /Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Chrom'c Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown o 9 Unknown ئە Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No 24a. Was an has autopsy performed 1 Yes 2 No or Vital To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ∏ Yes 2 ∏ No 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1<mark>√ CertIfying Physiclan:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and Itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8008, 75 1, MAN MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

MAY 0 1 2008

Tao



Summers

Avenue

Maryland

Baltimore

State Registrar

Registrar's Signature

Assistant Medical Examiner

une (

30. Name and address of person who completed cause of death (Item 23a)

Mome

Margarita Korell MD.

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 27, 2008

				Fleas	State of Mary	a per IVF	G879, 5/1/08, 1	Sith and Me	oples Are	e Legible.	
				T = For State Registrar	Otato of Mary		rtificate of De		Reg. N	2000	14288
		Physici /Medi		1. Decedents Name (First, Middle,	Ann Sel	ov			2. Date of Death	7ear Year	3. Time of Death
4		Examir			give street and number)	1	4b. City Town, or Loc			c. County of Deat	
		Funeral		5. Social Security Number	6. Sex 7. Age (In	yrs. last birthday)		Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	7	Director		Usual Residence of Decedent	1□ M 2 X F 5	Yrs.	Months Days F	lours Min.	B. Date of Birth (Month, Day, 186	56	wintry) WD
	broath with the Mandan	upon and a should be mad within 72 hours are bean with the way han year. He frem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, its Madical Examinar must be notified at	ctor	10a. State 10b. County	100	Balti	cation Nove				10d. Inside City Limits 1 ☑ es 2 ☐ No
	with th	3a or 28	al Director	10e. Street and Number	s Street, 2	and Floor	10f. Zip Code	30	10g. (Citizen of What Co	untry?
	à	items 2	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Decedent of Hispa f Yes, specify Cuban, N	nic Origin? (Spec Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
p.m.	21215-0036	Department of Health and Metal Hygiene, I mous after use Inportant: If item 27 is marked other than "natural", or items any Injury or other traumatic event, Its Madical Examiner manage.		1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 █ Divorced	If Yes, Give Year or Dates:		•	pecify:		Specify: B	ack
50 p	1215-	e. Malica	Completed by	15. Decedent's (Specify only highest Elementa y/Secoldary (0-12)	s Education grade completed) College (1-4or 5+)	Give	dent's Usual Occupation kind of work done durir DO NOT ase retired)		16b.	Kind of Business/	Industry
11:5		Hygien ther th		17. Father's Name (First, Middle, La	,	Ca	re (siver	Mother's Name (First, Middle, Maide	OVING	Care
· · ·	/lan	Wental rrked o	To Be		well		10.	Cherr	y Long	A	
2008	Maryland	trauma		19a Informant's Name/Relationshi	p (Type. Print) Daugh	(kr) 19b. Mailir	g Address (Street and	Number or Rural	Route Number, City	or Town, State, 2	Zip Code)
28,	ore, N	of Heal of Heal fitem 2 r other		20a. Method of Disposition	- Galbreath	Ob. Place of Dispo	sition (Name of natory or other place)	d F NWY	te 20c.	Location - City or	Town, State
11 2	Baltimore,	artment ortant: I njury o		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Section 2) 21. Signature of Funeral Service Lie	ecify)	king N	emorial	5.3	08 F	<u>Saitim</u>	ore, MD
APRIL	Balt	Impo any Ir once.		Vaugh	O. Miles	e 5	Vame and Address of	Nat'l	e Furer Piko (2	al Ser 1229)	vices
				23a. Part 1. Enter the se se, or conshock, or heart fall e. List or	omplications that caused the only one cause on each line.	death. Do not ent	er the mode of dying, s	uch as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
•	/	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCE						
	E	xaminer	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a con	sequence of):					
141	J. Sonted	ind transit	Examiner	that initiated events	с						
V	760, √	nysician and he burial-transit	cal Ex	resulting in death) Last	Due to (or as a con	sequence of):					
	r 687 ertificate	ing phy as the		IF FEMALE:	d						
h .	Records, P.O. Box 68 The law requires that the death certifica	he attending phy ed for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 [Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	, P.O that the	ned by the detached		9 ☐ Unknown Part II. Other significant condition		resulting in the ur	derlying cause given in	Part I.	23e. Did tobacco	use contribute to	the cause of death?
	ecords law requires	s been sign should be	ted by						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 X Unknown
PATRICIA	Rec he law r	cate has b	Completed						24a. Was an autopsy performed?	24b. Were au prior to death?	topsy findings available completion of cause of
PAT	Vital sician: ⊺	ertificat ctor, pa		25. Was case referred to medical examiner?			26.	Place of Death (1 □Yes 2 🛣 N	lo 1 □Yes	2 □ No
	Of V Physic	r this ce	6	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	2 ER/Outpatien					cify) HOSPICE
	Vision of Vita Attending Physician:	ath. or: After he funer	ation	1 Natural 5 ☐ Pending investigat	(Month, Day, Year tion	nr) Injury	28c. Injury at Work? M 1 □ Yes	2 🗆 No	d. Describe how inj	ury occurred	
	Division tal or Attending	# F	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		At home, farm, streecify)	et, factory, office	28	f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
	Hospital	24 hou	Medical	29a. Certifier (Check only one) 1 X Certifying 2 Medical Ex	Physician: To the best of my xaminer: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the time, ovestigation, in my opinion	late and place, ar	nd due to the cause I at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To the	within 2 To the comple	Me	29b. Signature and title of certifier		MI	29c. Ticense nur	mber	29d. P	ate signed (Montl	n, Day, Year)
				30. Name and address of person wh	on completed course of death	tom 232) (Time 1	Do.	214(PNI 30	in 5008
		2		DR. ERNESTINE W	RIGHT 2300 DU	ULANEY V		TIMONIUM	, MD 2109	93	
		Stat Registra		31. Date filed (Month, Day, Year) MAY 0 1	32. Redistrar's Si	ignature	borle .				

PATRICIA SELBY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** 2:00M /Medical or Location of Death (If not institution, give street and number, County of Death Examiner town 8. Date of Birth Month Day (State or Foreign Social Security Number **Funeral** 1 □ M 2 V F Director Usual Residence of Decedent City, Town or Location with the Maryland 10b. Count 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at atonsville 1 Mes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 228 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a any Injury or other traumatic event, the Medical Examinat must opnee. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT useful tired) ondary (0-12) College (1-4or 5+) Elementart/Se Be ပ 19a. Informant's Name/Rela Inship MD 21117 20c. Location - City or Town. State 20a. Method of Disposition Place of Disposition cametery, crematery 1 Burial 2 Cremation 4 Donation 6 Other (5 3 Removal from State Othen (Specify) 21. Signature of Funeral Se vice Lices Approximate Interval Between Onset and Death or complications that caused the death. 23a. Part 1. Enter the Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** tai /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the hurtal Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To Inpatient After this 27. Manner of Death 1 X Vatural 2 ☐ Accident Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of e (Item 23a) (Type, Print) 30. Name an oddress of person who complete 10 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	iryiand / i		rment of H ificate of I			Reg. No.	108	4290	
	Dhyaisi		Decedent's Name (First, Middle, Last,)					2. Date of De	Day	Year	3. Time of Death	
	Physicia Medic		Kathleen C. Sander				th Oh Taur	1 and the of Dooth	April		ity of Death	11:20 A.M.	
	Examin	er	4a. Facility Name <i>(If not institution, give</i> Baltimore Washingt		1 Cente	ì	Glen Bu	Location of Death	1		e Arur	nde1	
74	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th		place (State or Foreign ntry)	
	Director		213-52-5963]M 2[2]F	61	Yrs.	Months Days	TIQUIS IVIIII.	11/12/	1946		MD	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	ation	_				10d. Inside City Limits	
	Maryi -f sho led at	to	MD Anne Aru	ndel	Linthi	icum						1 □Yes 2 No	
	h the r 28a r notif	irec	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
	ath with	Funeral Director	208 W. Maple Road				21090			U.S.A	ace - Ameri	on Indian	
	er dea items ner m	ine	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No to Rican, etc.)	В	lack, White,	, etc.	
35	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by F	3 ☑ Widowed 4 ☐ Divorced	1 ∐ Yes 2 🔼 N If Yes, Give Year or Dates:		1	☐ Yes 21区 No	Specify:		Spe	cify: who	ite	
Š	72 hou natura lical E		15. Decedent's Edu (Specify only highest grad	ication le completed)	16a	(Give k	ent's Usual Occup	during most of wor	rking	16b. Kind of	Business/Ir	ndustry	
2	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5		`life. Di 1rse	O NOT use retired	1)		Nursi	nø		
Maryland 21215-0036	filed w Hygie ther th	CO	17. Father's Name (First, Middle, Last)	<u> </u>	INC.	1156	-	18. Mother's Nar	ne (First, Middle				
an	4 = 0 %	To Be	Edward Baust					Edith	Feehely	,			
ar _V	shou and M s mar	-	19a. Informant's Name/Relationship (7)	vpe. Print)	19	b. Mailing	Address (Street	and Number or Ri	ural Route Numb	er, City or Tov	vn, State, Zi	ip Code)	
Σ,	and 2 ealth a n 27 i		Mrs. Sandra Dorr	/ daughter				Road; Li	nthicum,	MD 21		Faur Ctata	
Baltimore,	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐		1		ition (Name of atory or other place	1			•		
<u>=</u>	it. Pa irtmen irtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Poreral Service License		Chesa			ion 4/2				lle, MD Cremation	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If ttem 27 is marked any injury or other traumatic en once.	. :	Volut Krede	· A.	101411		ervices					, MD 21061	
			23a, Part1. Enter the disease, or comp	lications that caused	the death. Do	not ente	r the mode of dyir	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death	
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	/Medical Examiner		resulting in death) Due to (or is a fonsequence of):										
	Ą. Ę.	e.	Sequentially list conditions, Thank bound to the final date. Due to (or as a consequence of):										
	ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C									
Ö,	e exe ian af urial-t	I Ex	resulting in death) Last	Due to (or as	a consequence	e of):							
68760,	ficate be executed physician and the burial-transit	edical		d		_							
Box 6		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of deli	very	
	law requires that the death certii as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnanc Other (specify) _	у			Month	Day Year	
P.O.	at the d by th etache	Phys	9 ☐ Unknown Part II. Other significant conditions or		ut not regulting	in the un	dadvina causa di	ven in Part I	23e Did	tohacco use o	ontribute to	the cause of death?	
	ires th signed	þ	Part II. Other significant conditions of	oninbuting to death b	uthotresuling	iii the un	dellyllig cause gi	en in Fait i.				obably 4 ∐Unknown	
202	v requ been should	Completed							24a. Was	san 24	4b. Were au	topsy findings available	
æ	The lav	duic							auto perf 1⊟ Yes	opsy formed? 2 A No	prior to death? 1 ☐ Yes	completion of cause of 2 \(\subseteq \text{No} \)	
or Vital Records,		Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only				
<u>></u>	Physician: r this certific ral director,	T0.	1 ☐ Yes 2 1 No	Hospital: Inpatie			I SLIDOA		Home 5□Res			oify)	
o uc	ding F	ion:	27. Manner of Death 1 Natural 5 Pending 2/17 Accident investigation	28a. Dáte of Inju (Month, Da		. Time of Injury	Wo	ryat rk?]Yes 2∐No	280. Describe	how injury oc	curied		
Division	Attending r death. ector: After by the funer	Certification:	2 ☐Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj	ury - At home,	farm, stre	eet, factory, office		28f. Location	(Street and No	umber or Ru	ıral Route Number,	
ă	tal or s after al Dir	Cert	4 I Hornicide	building, e	c. (Specify)				L.	omi, Gialo)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		(Check only Medical Exam	ysician: To the best niner: On the basis of	of examination a	ge, death and/or inv	occurred at the twestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	e cause(s) and e, date and pla	d manner as ice, and due	stated. to the cause(s)	
	o the lithin 24	Medical	one) 29b. Signature and title of certifier	and manner st	ated.		29c. Licen	se number		29d. Date si	gned (Mont	h, Day, Year)	
	To vit		b 60	EVO			NL	13977		AO N	711	2008	
,	50		30. Name and address of person who	1	death (Item 23a	(Type,	Print)	111/			7	p=4 ~ :)	
	9		Comple Forces cons	3011/2h	tal Der	RY	en Broy	me. M	1) 2106	9.			
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Hegist	rar's Signature	· Sand							
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DHMH 17 Rev 1/2001

KATILLED JANDELS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2·05PM 4c. County of Death Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 3723 Edmondson Avenue Baltimore 8. Date of Birth (Month, Day, Aug. 23, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Hours Days Min. 1 □ M 2 30€ 212-16-9791 Aug. 77 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Ves 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3723 Edmondson Avenue 21223 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify. Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) custodian Johns Hopkins University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Palmer Nannie Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pamela Bishop / Daughter 306 South Mt. Olivet Lane; Baltimore, Maryland 21229 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 05/05/2008 Woodlawn, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) es a consequence of) σ_{V} Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical **Examiner** Examiner

certificate be executed

Box 68760,

P.0.

Division or Vital Records,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

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After this funeral

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24 hours a e Funeral I

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Completed

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Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical examiner?

3 ☐ Suicide

29a. Certifier

4 🗌 Homicide

6 ☐ Could not be

coursem AUU

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

3100 Towarda Ave, Bultimore MD21215 ·UFOMA

31. Date filed (Month, Day, Year) MAY 0 1 2008

32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

			1- State of Maryland State of Maryland		rificate of L			giene / Reg. No.	008	14292	
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic		Donald Schnick				April	24	700F	15:574W	
)	Examin	er	4a. Facility Name (If not institution, give street and number)	1	4b. City, Town, or	Location of Death	,	4c. County of Death			
	Funeral		5. Social Security Number 6. Sex 7 Age (In yrs. I	(ast birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace						pplace (State or Foreign	
	Director		215-05-7165 X M 2□ F 91		Months Days	Hours Min.	Oct. 2	_{ly, Year)} 5 , 1916	Cor	uintry) MD	
ī	nd ,		Usual Residence of Decedent	Town or Loo	ation						
	larylan show ed at	'n		y, Town or Loca	ation					10d. Inside City Limits 1 ☐ Yes 2√ No	
	the N 28a-f notifie	Director	MD Baltimore 10e. Street and Number	Reiste	rstown 10f. Zip Code			10a Citize	n of What Co		
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	death	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. W		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No	- 14	. Race - Amer		
0	after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		Tes, specily Cuba ☐ Yes 2X No		nicari, etc.)		Black, White	e, etc.	
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<u>a</u>	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)			nd Number or Rui				(ip Code)	
ָט ע	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mentail Hygiene. If Health and Mentail Hygiene. It filed 12 is marked other than "natural" or items 23a or 28s-f show other traumatic event, the Medical Examiner must be notified at		Donna Schnick Daughter 20a. Method of Disposition 20b. P	5332 Place of Disposi	Kelmscot ition (Name of atory or other place	Road, Ro	osedale Date		21237 Ition - City or	Town, State	
	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		I Duliai 2 Acientation 3 Differnoval from State		atory or other place remation	1	5/08	Цот	natood	MD	
	permit. I Departm Importar any Injur		21. Signature of Funeral Servige Licensee		Name and Addres				ipstead Isterst	own Road	
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ê.	/Medical Examiner		resulting in death) Due 16 (or as a consequ	uence of):	4	,	,				
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5	Phys r this ral di	: To	1 Yes 2D No Hospital 1 inpatient 2 27. Manner of Death 28a. Date of injury	ER/Outpatient 28b. Time of	3 DOA Our	4 LI Nursing Ho	ome 5 Res 28d. Describe			cify)	
5	ndIng Ith. r: Afte e fune	ition	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Work	í? Yes 2 □ No		,,,,,			
2	er dea rector by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At he building, etc. (Specific		et, factory, office		28f. Location (Street and wn, State)	Number or Ru	ıral Route Number,	
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)	wledge, death tion and/or inve	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) a , date and p	nd manner as place, and due	s stated. e to the cause(s)	
	o the	Mec	29b. Signature and title of certifier		29c. License	number		29d. Date	signed (Mont	h, Day, Year)	
)	->-0		11:1 125:1		1-111	29711		Abr:1	74	2012A	
	150,		30. Name and address of person who completed cause of death (item	1 23a) (Type, P	rint)	1/4		7			
	(0.,		Alive Hsints Worthin	ust	HOSPIT	of Ra	14/11	town	n, be	ary find	
	Sta Registr		31. Date filed (Month, Øay, Year) 32. A figistrar's Signa MAY 0 1 7008	ture.	2346	ť				1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 9-2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner al stown if Unde 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Davs 1**X**ÎM 2□ F Sept 30,1952 218-62-0360 55 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 USA 12026 Reisterstown Road Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give' Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event and once. Elementary/Secondary (0-12) College (1-4or 5+) Manager Car Wash 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leona Blucher Mitchell Stevens ျှ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12026 Reisterstown Road, Reisterstown, MD 21136 Wife Sibyl Stevens 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation 4/30/08 Hampstead, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final irrhosis **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 4 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform certificate 1□ Yes To the Hospital or Attending Physician: after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? 26. Place of Dea . Check onl one Be Other: 1 ☐ Yes 2 100 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Horsing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? injury (Month, Day Year) 1 A Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 [Beertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 296. Signature and title of certifie 3 30. Name and address Pandalktown, MD 21133 Koa 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕕 🖯 🖰 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month APRIL Day Year **Physician** SMUTH 10:40 AM 2008 C58 . MARION " /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. our 20h Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 212-28-986 Usuel Residence of Decedent 1 □ M 2 🛛 F Yrs. ashington, Director 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director nore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number TOD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 Yes Cive 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balto, City IL 2 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I reen 19b. Mailing Address (Street and Number or Rural-Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Si Ster) Health a 20b. Place of Disposition (Name of cometery, crematory or other place) Heal 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 10n permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home, Balto Md Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INFECTION WOUND **Physician** ABDOMINAL /Medical Due to (or as a consequence of): **Examiner** RENAL TNSYFFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed BILATERAL Due to (or as a consequence of) physician RTERIOSCLEROTIL DISEASE Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 XNo 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown OTHY ROIDISM Completed peen 24b. Were autopsy findings available prior to completion of cause of death? MELLITUS 24a. Was an DIABETES autopsy performed? 2 No 1 Yes 1 ☐ Yes 202 No 25. Was case referred to medical 26. Place of Death (Check only one)

Box 68760. Division of Vital Records. P.O. certificate has or Attending Physicien: After this death. the

27. Manner of Death

1 ☐ Yes 2 No

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Certification; To To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A Medical

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATEL. SUDHIR.

MD 2000 W

32. Registrar's Signature

Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

and manner stated.

D 23300

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) APRIL 27 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BON SELONAS H23/

13425435 13A2TU MOD,

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Sports

5 Pending

investigation

6 Could not be determined

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Na._ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Month **Physician** April 22, 9:25 AM M Vivian M. Simmons /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Manor Care Towson 9. Birthplace (State or Foreign Country).
Georgia 8. Date of Birth (Month, Day, Year) Sept 27, 1927 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F 80 Director <u>257-30-8</u>028 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Funeral Director Parkton MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 19622 Downes Road #B 21120 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【 No Specify: Baltimore, Maryland 21215-0036 Specify: white þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 A&P 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George H. Duffy Anne M. Kugler ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stanley H. Bowen/son 19622 Downes Road #B Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signalur of Funeral Service Licensee Ronald S. Wade rector 21201 Baltimore, MD Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause in each line. 23a. Part1. Enter the disease, shock, or heart failure. L Immedia Cause (Final disease or condition resulting in deeth) neumonia **Physician** iration /Medical Due to (or as a consequence of) s Phasia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1∏ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Division 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 140054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asadi, 2cE. Timenium rd. #209 Timonium, MO 21093 yous 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 1 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 12:04 A M Dorothy H. Talley APRIL 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL OF BALTIMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Davs Hours 1 □ M 2 🖾 F 217-24-2748 76 Feb 16, 1932 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f showevent, the Medical Examinar must be notified at 1√2 Yes 2 □ No MD Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 3405 Keston Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No 2 Specify: black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) machine operator McCormick & CO 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clifton Hardy Viola Mathew injury or other traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trauonce. Mary M. Brown/sister 4301 Ethland Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service . Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTRACEREBRAL DAY HEMORRHAGE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by certificate has been sign irector, page 2 should be 3 Probably 4 Unknown 1 ☐ Yes HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this

filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APRIL 28,2008 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OF BALTIMORE HOSP ITAL SENGUPTA SINAL SOMA 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 1 2008

DHMH 17 Rev 1/2001

'Registrar

State of Maryland / Department of Health and Mental Hygiené. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Regina 8 20 PM 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Rehab & Nursing Burtonsville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 84 Director 214-22-2672 July 10, 1923 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28s-1 show eny injury or other treumatic event, the Medical Examinar must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Columbia Director 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5343 Harpers Farm Road 21044 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 clerical Dept of Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Whitfield 2 Bessie Parson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shellie Brown/daughter 5342 Harpers FArm Road Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of Euneral Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director w Baltimore, MD 21201 art1. Enter the dial ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart faiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician To Thrive Failure /Medical Due to (or as a consequence of): Examiner Vascular dementia Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (un as a consequence of). Examine The law requires that the death certificate be executed Cerebral Vascular Due to (or as a consequence of): by the ettending physicien a tached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 1No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificete l 1 Yes 1□ Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident after death Director; , I in by the f 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide n 24 hou. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053337 4-21-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avenue Suite 203 Baltimore, Md zizoq 2835 MI 32, Registrar's Signature State Tar/2008

Registrar

DHMH 17 Rev 1/2001

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State Registrar 31. Date filed (Month, Day, Year) MAY 0 1 2008

29b. Signature



eted cause of death (item 23a) (Type, Print)

10700 Charter Drive Suite 200

29c. License number

065776

29d. Date signed (Month, Day, Year)

April 28, 2008

State of Maryland / Department of Health and Mental Hygiene (1) 8

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Baltimore, Maryland 21215-0036		die
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene		
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	unera irecto	Fvam

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	D!!!		1. Decedent's Name (First, Midd	lle, Last)					2. Date of De	eath Da	y Year	3. Time of Death		
	Physici /Medio		Lorraine M. Va	in					April		008	9:45 PM M		
de	Examir		4a. Facility Name (If not institution	-	ber)			or Location of Dea	ath		. County of De			
			6839 Belclare				Baltim				Baltimo			
	Funeral Director		5. Social Security Number 216–20–2561	6. Sex 1 □ M 2 💢 F	'. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Yea Months Day			rth la <i>y, Year)</i> 3 , 19		irthplace (State or Foreign Country) ryland		
	and and		Usual Residence of Decedent 10a. State 10b. County	/	10c. City	y, Town or Lo	cation					10d. Inside City Limits		
	Mary f sh	호	MD Baltin	nore		Balti	more					1 □Yes 2√ No		
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What C	Lountry?		
	h with	a D	6839 Belclare	Road				21234			US	A		
	ems ems	iner	11. Marital Status	12. Was Deced	ent Ever in U.s	S. 13.	Was Decedent of	Hispanic Origin? ban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - An Black, Wh	nerican Indian,		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Madical Examinat must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 💆 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	9		1⊡Yes 2 X N		,			white		
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121	within ene.	dmc	Elementary/Secondary (0-12)	College (1-4	1or 5+)	`life. I	DO NOT use retir	ed)	9					
	filed Hygi other		17. Father's Name (First, Middle					18. Mother's N	ame (First, Middle	e, Maiden	Surname)			
an	ld be fental rked ic ev	Mike Jagdoski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street						Sophie	Jagdosk	i				
ary	should I and Men s marke umatic										or Town, State	, Zip Code)		
Z,	and 2 salth a 127 is er tra		Francis Vain/s	pouse		6839	Belclare	Road Ba	ltimore,	MD	21234			
Baltimore, Maryland	20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State 4 \(\Delta\) Donation 5 \(\Delta\) Of the (Specify)						sition (Name of natory or other pi	асе)	Date	20c. L	ocation - City o	or Town, State		
Balti	permit. Departr Importa any Inju	21. Signature of Euneral Service Licensee Renaid S. Wade, Director 22. Name and Address of Facility State Anatomy Board								1 655 W. Baltimore Street				
			23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	Physician		Immediate Tuse (Final disease or condition	t only one cause on ear	on line.	Lux	11100	ut fo	i Pun			Approximate Interval Between Onset and Death		
	/Medical		resulting in death)	a. Due to (o	r as a contequ	ence of):	i per					gena		
	Examiner	L	Sequentially list conditions.	b	0							1 0		
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):											
	execui and al-trar	xan	that initiated events resulting in death) Last	c Due to (o	r as a consequ	ence of):								
68760,	ficate be executed physician and s the burial-transit			d										
.89	rtificat ng phy as the	Medical		u.								West .		
Вох	eath cer attendin for use	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna		Ectopic pregna	201/			23d. Date of d	lelivery		
О. В	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, lage 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		int at time of d		Other (specify)	icy .			Month	Day Year		
σ.	that the dended by the a		Part II. Other significant conditi	ions contributing to dea	th but not resu	Iting in the ur	nderlying cause g	iven in Part I.	23e. Did	tobacco	use contribute	to the cause of death?		
Records,	quires n sign	d bé	Dementi	1					1 🗆	Yes 2	ØNo 3□	Probably 4 🗍 Unknown		
9	s seen s s seen s s hould	lete							24a. Was		24b. Were	autopsy findings available		
Ä	The law te has age 2 a	Completed by							- auto perfe 1 □ Yes	ormed2	death'	o completion of cause of ? es 2 □ No		
Vital	sician: Th certific te rector, ag	Be	25. Was case referred to medica examiner?	ıl				26. Place of D	eath (Check only		, , , , ,	70 2 2 110		
of V	hysic his co	인	1 Yes 2 No	Hospital: 1 ☐ In	patient 2 🗆	ER/Outpatier	IL 3 LI DOA		Home 5 Res	idence	6 □Other (Sp	pecify)		
	5 0 0 0	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at							28d. Describe	how inju	ry occurred			
Sio	Attending or death. ector: Afte by the fune	icati	2 ☐ Accident invest	not be	f Imirana At Inco			⊒Yes 2 □ No	20f Location	/C44		D. J. D. Ja March		
Division	ital or A	Certification:	4 Homicide determ	mined 28e. Place o building	g, etc. <i>(Specif</i> y	me, iarm, sin	eet, factory, office		City or To	wn, State	na Number or I	Rural Route Number,		
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier 1 ☐ Certifyi (Check only one) 2 ☐ Medica	ng Physician: To the basing Examiner: On the basing and manner	sis of examinat	wledge, death tion and/or in	n occurred at the vestigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s , date an	s) and manner d place, and d	as stated. ue to the cause(s)		
	Vithi Comp	ž	29b. Signature and title of certific		A		29c. Licei	nse number		29d. Da	ate signed (Moi	nth, Day, Year)		
			If the	they the	Ly.	; wy	02	25205		AV	1r.18	2008		
			30. Name and address of person		of death (Item	23a) (Type,	Print)	Charl	e St.	Bou	lto no	2008 1 2008		
	Sta		31. Date filed (Month, Day, Year,	2008 3 Re	gistrar's Signa	ure do	de							

	ical ner	4a. Facility Name (If not institution,			41	Cumbox		of Death		4c. County of D			
		12413 Crossroa 5. Social Security Number		je (In yrs. last b	irthday) II	Cumber Under 1 Year		24 Hrs. 8. Da	ate of Birth	Allegan	y Birthplace (State or		
neral ector		220-30-8271 Usual Residence of Decedent	1∭M 2□F	75		onths Days	Hours	Min. (A	fonth, Day, Ye	.932 Ma	Country) aryland		
tified at	Director	MD Allega	ıny	10c. City, To	wn or Locati er1and						10d. Inside City 1 ☐ Yes		
The D	Dire	10e. Street and Number 12413 Crossroad	Court			10f. Zip Code 2.1	502		10g.	Citizen of What USA	: Country?		
Examiner musi	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent	? No		Decedent of Hes, specify Cuba		gin? (Specify Y , Puerto Rican	es or No- , etc.)	14. Race - American Indian, Black, White, etc. Specify: white			
Madical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		16	(Give kind	's Usual Occup d of work done o NOT use retired	durina most	of working	16b	. Kind of Busine	ess/Industry		
3	Som	12	0	t	racto	traile				O&R True	cking		
atic avant	To Be (17. Father's Name (First, Middle, Lanwood Walker	ast)						t, Middle, Maid ina Gro	,			
er treum		19a. Informant's Name/Relationshi Alena Walker/spo				Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crossroad Court Cumberland, MD 21502							
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f ahow important: If item 27 is marked sevent, it is Medical Examiner must be notified at ance.				comet	p. Place of Disposition (Name of cametery, crematory or other place)						or Town, State		
any Inju		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Section Consequence Director States and Astronomy Baltimore, MD 21201									altimore Street		
hat the death certificate be dd by the attending physicis stached for use as the bur		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Small Cell Cause (On Cell Cause) Due to (or as a consequence of):								Approximate Interval Betwoonset and D			
	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C											
	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deat		opic pregnancy her (specify)				23d. Date of delivery Month Day Year			
	d by P	Part II. Other significant condition	s contributing to death b	out not resulting	in the under	rlying cause give	en in Part I.	2	3e. Did tobaco		e to the cause of de] Probably 4⊠Ui		
ep ed blu	Completed	25. Was case referred to medical		-				1	4a. Was an autopsy performed	? prior deati			
or, page 2 should be de	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ER/C	utpatient :	3□ DOA Oth	00	of Death Che		6 □Other (5	Specify)		
director, page 2 should be de	o Be	27. Manner of Death				28d. E	Describe how in	njury occurred					
y the funeral director, page 2 should be de	To B	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
filled in by the funeral director, page 2 should be de	Certification: To B	1 SNatural 5 Pending 2 Accident investiga 3 Suicide 4 Homicide Certifier 129a. Certifier 15 Certifying	28e. Place of Inbuilding, ei	tc. (Specify) of my knowledg	je, death oc	curred at the tin	ne, date and	d place, and du	ue to the cause	s(s) and manne	r as stated.		
completely filled in by the funeral director, page 2 should be de	To B	1 SNatural 5 Pending 2 Accident investiga 3 Suicide 4 Homicide Certifier 129a. Certifier 15 Certifying	t be 28e. Place of In	of my knowledger of examination a	je, death oc	curred at the tin	pinion, deat	d place, and du	ue to the cause the time, date	and place, and	r as stated. due to the cause(s)		

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#244-30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 04 24 2008 Ann Louise Woods 7:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2651 Edmondson Avenue Baltimore 5. Social Security Number 213–32–7665 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 ☐ M 21X7XF 74 SC Director Mar. 15, Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 XX es 2 □ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2651 Edmondson Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 registered nurse Bayview Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Blair Pauline Myers ۴ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie Woods / Daughter 420 E. Biddle Street; Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/30/2008 Mount Carmel Cemetery 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 1 Yes 2 No 9 Unknown 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown þ Completed Be Certification: To

Division or Vital Records, P.O. Box 68760 o the Hospital or Attending Prithin 24 hours after death.
o the Funeral Director: After it completely filled in by the funera within 24 hours at To the Funeral E

Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1								
		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 7 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify)									
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 12 Certifying Pt 2 Medical Example 1	ysician: To the best of my knowledge, death occurred at the time, date and plac niner: On the basis of examination and/or investigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)								

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OBAZE

Registrar's Signature

State Registrar

Medical

29b. Signature and title of certifier

08-03145

Mi

ichael Freder	ick V	1- For State amend #21 PerFH G879 5				lygiene	200	8 1430
Physic ledical Exam		Decedent's Name (First, Middle,Last)				2. Date of Death Month April 23, 20		3. Time of Death 1240 hrs
		Facility Name (if not institution, give street and number) 10424 Brighten Road		4b. City, Town, Ocean Cit	or Location of Deat y		4c. County of Dea Worcester	h
Funeral Director			rs. last birthday)		ear If Under 24Hr ays Hours Mir		1949 Fore	
Maryland 28a-f show any 1 at once.	Director		Ocean			I 10	og. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Mechadical Examiner must be notified at once.	Funeral Dire	10424 Brighten Rd. 11. Marital Status 1 Never Married 2 Married Armed Forces?		2184 Was Decedent of H	2 Hispanic Origin?(S	pecify Yes or No-	USA	rican Indian, Black,
hours after de 'natural', or i	ed by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed	1 16a. Dece	Yes 2X N dent's Usual Occup g most of working li	ation (Give kind of		Specify: 16b. Kind of Business	White /Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medichan."	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 4 yrs	Owne	er		•	Glass Inst	tallation
MD 2121 od 2 should be fi lith and Mental m 27 is marked aumatic event,	To Be	Gerard Wallnofer 19a. Informant's Name/Relationship (Type, Print) Jeffrey Wallnofer Son		iling Address (Str		Rural Route Num	iber, City or Town, Statity, Fla.	, ,
Baltimore, I bermit. Pages I and Department of Healt Important: If item njury or other tra		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or Bayview		4-2	Date 28-2008	20c. Location - City of Balto.	
Balt Balt Balt Balt Balt Balt Balt Balt		21. Signature of Funeral Service Licensee Diane Gnade, M01514 per DVR 23a. Part I. Enter the disease, or complications that caused the de			k Funeral		705 Belair	Rd .
/Medical xaminer	8	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Complications of Due to (or as a consequence)	f chronic					Between Onset and Death
cecuted and - transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	- ed recht					
60, nte be execut hysician and e burial - tra	Medical	d. X UNPENDED AMENDED 23d, F2, 17, perME, C879 5/13/08 TT						
Box 68760, c death certificate be the attending physic ed for use as the bur	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2	Fetal death 3 Other (Specify)	Ectopic pregn	ancy	Month	Day Year
ires that the signed by t	by	Part II. Other significant conditions contributing to death but not be Hepatitis C	ot resulting in th	e underlying cause	given in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should be	Completed	25. Was case referred to medical		OS Die	ce of Death (Check	24a. Was a autops perfor	sy prior to med? death?	outopsy findings available completion of cause of
_ = . ₹ .≥	on: To Be	examiner? Hospital: 1 Inpatient 2 27. Manner of Death 1 Noture (Month, Day, Year)	Othor:	ng Home 5	Residence 6 Oth	er: Scene		
Division Hospital or Attendii 24 hours after death. Funeral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	At home, farm, si			28f. Location (S or Town, Si		tural Route Number, City
To the Hos within 24 h To the Fun completely	Medical (29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination and manner stated.		gation, in my opinio	on, death occurred		and place, and due to t	he cause(s)
	M	29b. Signature and title of certifier	2 .		c.M.E.		29d. Date signed (M April 24, 2008	onth, Day, Year)
S	tate	30. Name and address of person who completed cause of death (II Zabiullah Ali, M.D. Assistant Medical Examin 31. Date filed (Month, Day, Year) 32. Registrar's Sigr	ner 111 Po	enn Street, Ba	Itimore, MD 2	1201		
Regis		APR 3 0 2008	N 1300	462				

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			For State Registrar	State of Ma	aryland /	-	tment of H ficate of I		Mental Hy	giene Reg. No.2	800	14303
	Physicia	an.	1. Decedent's Name (First, Middle	e, Last)					2. Date of De	eath Day	Year	3. Time of Death
. *	/Medic		Laura B. Wile	*					April	21	2008	8:42AM
	Examin	er	4a. Facility Name (If not institution Washington Co	, 6	.1		b. City, Town, or Hagersto	Location of Death	1 [ty of Death ington	
_	Funeral		5. Social Security Number		e (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth		place (State or Foreign
	Director		203-20-5956	1□M 2∏F	79	Yrs.	Months Days	Hours Min.	Sept 1	ay, Year) 5 , 1928	Penn	sylvania
	put »		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Locat	tion					10d. Inside City Limits
	f shoved at	o	MD Washi	ngton		gersto						1 □ Yes 2√□ No
	the N 28a-	rect	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	h with 23a ol st be	al Di	11 S. Walnut S	treet 316B				21740		U	SA	
	ems;	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa	s Decedent of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 14. Ra	ace - Americ	
36	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ∏ Yes 2 🔼 If Yes, Give Year or Dates:	No		Yes 2 X No	Specify:			eify: whi	lte
15-0036	2 hour atural cal Ex	ed t	15. Deceden	t's Education	16	a. Deceden	nt's Usual Occup	ation		16b. Kind of	Business/In	dustry unk
212	within 72 ene. than "na he Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5	i+)	(Give kin life. DO	nd of work done o NOT use retired	during most of wor d)	rking	*		
2121	filed wit Hygien other tha	Con	12	0	,	S	tenogra					
Maryland		Be	17. Father's Name (First, Middle, Howard Clevel					18. Mother's Nan	ne <i>(First, Middle</i> 1 th Ga mb	•	ame)	
3	d 2 should be th and Mental 7 Is marked o traumatic eve	ᅀ	19a. Informant's Name/Relations		10	9b Mailing	Address (Street	and Number or Ru			n State 7ii	n Cade)
	d 2 s thar 7 ls trau		Frank D. Wiley		'	•	,	Avenue Ha			21740	,
Baltimore,	of H		20a. Method of Disposition 1 ☐ Burial →2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (S		20b. Place cemei	of Dispositi tery, cremai	on (Name of tory or other plac	ce)	Date	20c. Location	ı - City or To	own, State
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Ronald		ector	Sta		omy Boar		. Balti	more S	Street
÷.			23a. Part1. Enter the disease, or shock, or heart fallure. List	complications that caused	the death. Do	o not enter	timore, the mode of dyin	MD 2120 ng, such as cardia		arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Wa	morre	Ċ						Onset and Death
	/Medical Examiner		resulting in death)	a	a consequence		**************************	1	12.			11-
	Lxammer	<u>.</u>	Sequentially list conditions,	b. Chymu	a consequence	e off:	urg	Discose	Graced	atun'	-	TEARS
	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		e and		61					lateoks.
o,	ficate be executed physician and s the burial-transit	Еха	resulting in death) Last		conseque		in .	4.				W CCC /
98760	ite be iysicia ne bur	dical		La. Coron	my 1	Artery	Discess	<u> </u>				YEARY.
	ertifica ing ph e as th	Med	IF FEMALE:		U							
ROX	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 ☐ Fetal dea	ith 3⊟Eo	ctopic pregnancy	/		I .	Date of deliv Month	rery Day Year
o.	the de	ysic	1 ☐ Yes 2 점 No 9 ☐ Unknown	4∐Pregnant at 9∐Unknown	time of death	200	other (specify)					
<u>. </u>	The law requires that the de ite has been signed by the a bage 2 should be detached	by Ph	Part II. Other significant condition	ons contributing to death b	ut not resulting	in the unde	erlying cause glv	en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
g	equires en sig vuld be	q pa							1 🗆	Yes 2 No	3 ☐ Pro	bably 4 Unknown
Records,	EE 62 01	Completed							24a. Was			opsy findings available ompletion of cause of
		Som							perf 1∐ Yes	ormed? 2 No	death? 1 ☐ Yes	2 19 No
VItal	siclan; The Is certificate ha irector, page 2	Be	25. Was case referred to medica examiner?	Hospital:			all DOA Oth	26. Place of Dea	ath (Check only	one)		22 22
ō	Phys r this ral dir	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju		Outpatient Time of	3 DOA	4 LI Nursing F	lome 5 ☐ Res	idence 6 C		ify)
O	th. : Afte	tion	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	g (Month, Da		Injury	28c. Injur Wor M 1 □	k?¯` Yes 2∐No	204. 20001120	now injury coo	arrod	
DIVISION	Atter r dear ector by the	Certification:	3 Suicide 6 Could determ	ined 26e. Place of Inj	ury - At home, c. <i>(Specify)</i>	farm, street	t, factory, office		28f. Location	(Street and Nur	nber or Rur	al Route Number,
5	ital or rs afte ral Dij	Cert		Sanamy, ea								
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical		ng Physician: To the best Examiner: On the basis o and manner st	f examination a		stigation, in my o	opinion, death occ				
	To t To t	Σ	29b. Signature and title of certifie	10			29c. Licens	e number		29d. Date sign	ned (Month,	
)				J'ledu/			1 1	146361		Howe	21	2008
	865. G		30. Name and address of person	ADIR 20.	` .	(Type, Pri	//	Boon	s Bono	mi)	217	13
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 0 1		Red M	Sos	all .					

Emmanuel Werth		I- For State	State	of Maryla		rtment of tificate of	f Health an f Death	id Mental I	Hygie	ene Reg.	No	onn	8 11.30
Physicia	n/	1. Decedent's Name (F			G	WERTH			I м	ate of Death	Dav	Year	3. Time of Death 0740 hrs
Medical Examir	-	EMANUE 4a. Facility Name (if no					4b. City, Town, o	r Location of De		oril 27, 20	4c. Cou	unty of Death	
		7121 Park He	eights Avenue				Baltimore					N/A	
Funeral Director		5. Social Security Nun 215-09-656		M 2 F		In yrs. last birthday) If Under 1 Year If Under 24F 95 Yrs. Months Days Hours M			4in	Date of Birth		Foreig	hplace (State or n untry) MD
	ŀ	Usual Residence of D		M 2 F		Yrs	5.	00/21					
w any	1		b. County			Town or Local							10d. Inside City Limits 1 X Yes 2 No
yland -f shov	ġ	MD 10e. Street and Numb	N/A			BALTIM(of What Cour	
ith the Maryland 23a or 28a-f show notified at once.	Director	7121 PARK		S AVENU	E, APT.							ISA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married	2 Married	Armed Fr	edent Ever in U. prces?		as Decedent of H res, specify Cuba					Race - Ameri White, etc.	can Indian, Black,
ter dear		3 X Widowed		1 Yes	2 X No	1	Yes 2 X N	o specify:			Spe	cify: WH	ITE
ours af	d bg	15. Decedent's Educ	cation (Specify o	or Dates: nly highest grad	le completed)	16a. Decede	nt's Usual Occupa	ation (Give kind	of work	done	16b. Kind	of Business/I	ndustry
36 nin 72 h s. than "n dical E	Completed	Elementary/Second	dary (0-12)	College (1	-4 or 5+)		FACTURER			- 1		CIGARS	
5-0036 led within 7 Hygiene. I other than	Com	17. Father's Name (Fi	irst, Middle, Last			1 11 11 10 1	NOTONEN	18. Mother's Na				name)	
2121, Montal Filmarked	Be	MILTON 19a. Informant's Name	- (Deletionabie /		HEIMER	10h Mailir	ng Address (Stre		SAL I		er City o		SUMP Zin Code)
MD 2 d 2 shoul lith and M m 27 is m	ဥ	ROBERT WE					GREENLEA						
re, N s 1 and f Health If item er trau		20a. Method of Dispos		Removal fr		crematory or o	sition (Name of c		Da	l.		ation - City or	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5	Other Specify		В.		RE HEBRE					IMORE,	
Bal permit Depart Importing		21. Signature of Fune		nsee			Name and Addre						, INC. , MD 21208
Physician		23a. Part I. Enter the failure. List only	disease, or comp	olications that cach line.	aused the death	. Do not enter	the mode of dyin	g, such as cardia	ac or res	piratory arres	st, shock,	or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Fig or condition resulting			ve Atheroscl		diovascular D	isease					Death
		Sequentially list conditions, b											
	nine												
ecuted and and transit	Examiner												
ज्ञां क	edical	UNPENDED			ME , g879 5	/13/08 T	ਾ						
760, icate be physic the bun	/Mec	IF FEMALE: 23b. Was decedent pr	regnant in the	23c. If yes,	outcome of preg	nancy		Cotonio pro	00000			ate of deliver	y Day Year
Box 68760, s death certificate be the attending physic of for use as the bur	sician/M	past 12 months?		7	oirth nant at time of de	noth =	etal death 3 Other (Specify)	Ectopic pre	griancy		I MC	anu:	Jay Tea:
. Bo he deat y the at	Phys	1 Yes 2 No		9 Ulkii		esulting in the	underlying cause	e given in Part I		23e. Did tot	pacco use	contribute to	the cause of death?
, P.O. ires that the signed by the detach	þ	Complication		-	o death but not i	esalang in the	dilderlying dads	grenni acti					bably 4 🗸 Unknown
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed									24a. Was a		24b. Were a	utopsy findings available completion of cause of
(ecol	omp	· · · · · ·								perfori		death?	es 2 No
tal Rection: The certificate	Be C	25. Was case referre						ce of Death (Ch					
F Vit	To E	1 ✓ Yes 2 27. Manner of Death	No	Hospital: 1 28a. Date	Inpatient 2	ER/Outpatier	hammer)	Other No		d. Describe h		e 6 ✓ Othe	r: Scene
~ <u>=</u> `~	tion:	1 Natural	5 Pending	Unknov	n, Day,Year) VD	UNKNOW		Yes 2 V No	Su		fall in F		nd became
Division ratendir rs after death	Certification:	2 Accident 3 Suicide	Investigate 6 Could no	be 28e. Plac	ce of Injury - At h	ome, farm, str	eet, factory, office	e building, etc.					ural Route Number, City Baltimore, MD
Divi	Cert	4 Homicide 29a. Certifier	determine	(0,000.1)	Multi-Fam	<u> </u>		data and place					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Obserts seeks	Certifying Physic Medical Examine	r:On the basis and manner	of examination a	ige, death occ and/or investig	urred at the time, ation, in my opini	on, death occur	ed at th	e time, date a	and place,	and due to t	ne cause(s)
To vit	Me	29b. Signature and ti	tle of certifier	and manners	stateu.			nse number					onth, Day, Year)
10		IMI	1	- Anna Anna Anna Anna Anna Anna Anna Ann		- 00-1	0.0	C.M.E.			April 2	28, 2008	
12		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
	ate			64/-	egistrar's Signat	ure And	de						
Regist	relî	Ma	U L CUI	JU PARA	Albert For	0							

			1 - State Registrar			Certificate of	Death		Reg. No.	108	4305
Н	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Gwendolyn		shley			April		2008	7:56A M
	Examin	er	4a. Facility Name (If not institution, give				r Location of Death	1		nty of Death	K 3.7
			3319 Kilkenny S 5. Social Security Number 6. S		(In yrs. last birti	Silver		8. Date of Birl	th	gome	L y lace (State or Foreign
ì	Funeral Director		7000	M 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		rs. Months Days	Hours Min.	Sept. 1	y, Year)	Coun	try)
	land ow		10a. State 10b. County	1	I0c. City, Town	or Location	-			1/	0d. Inside City Limits
	Mary f sh	ţo	MD Montgom	ery	SIlv	er Spring					1 XYes 2 ☐ No
	r 28a noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Coun	try?
	h with	a D	3319 Kilkenny S	treet	20904					USA	
	deat	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent of H	lispanic Origin? (S	pecify Yes or No		lace - America	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ance.	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 XNo If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:	,,	Spec	77	lack
2-0	72 hc natul lical	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done	during most of wor	rking	16b. Kind of	Business/Inc	dustry
7	ithin nan "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired	d) -				
7	ygier ygier it, the	ខ		4	Aa	ministrat	ive Ass	t.	P1	rivate	2
and D	be fill	B	17. Father's Name (First, Middle, Last) Prince Jim H. Ash	1011			18. Mother's Nar	garet :	, waiuen sum Tollice	Byrd	
3	ould 1 Mer narke	မှ		_	106	Mailing Address (Street		-			
Maryland	12 sh th and 7 is n traun		19a. Informant's Name/Relationship (** Daena			19 Kilken					- 00004
	1 and Healt em 2 ther		Lorryn D. Logar 20a. Method of Disposition	ı – daughte				Date		n - City or To	
altimore,	ages nt of . If it		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		Disposition (Name of y, crematory or other place Universi			Washi	•	
量	it. Pa intme intant injury		4 Donation 5 ☐ Other (Specification of Funds Service 1.1)		noward						eral Home
Ba	permi Depar Impor any Ir		Just 1	00	, ~	3821 14t	h Stree	t, NW, W	ashing		DC 20011
П			28a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line	ne death. Do n	ot enter the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	a. Gasti	ric (ancer					
	/Medical Examiner		resulting in death)	Due to (or as a	consequence o	rf):					
В	Lxammer		Sequentially list conditions,	b		0-					
	be fi	Examiner	Sequentially list conditions, if any, leading to immediate cause Entai Underlying Cause (Disease or injury								
	ecut and I-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
60,	be ey ician burial			Due to (or as a	consequence o	.,,.					
68760,	ertificate be executed ling physician and e as the burial-transit	Medical		.d							
	leath certificate be executed attending physician and for use as the burial-transit		IF FEMALE:	23c. If yes, outcome pf	pregnancy				234 1	Date of delive	200
B	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti	☐ Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		- 1	Date of delive Month	Day Year
o.	the d y the ched	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown							
Division or Vital Records, P.O. Box	The law requires that the death os ate has been signed by the attendi bage 2 should be detached for use	by Physician/	Part II. Other significant conditions	ontributing to death but	not resulting in	the underlying cause giv	en in Part I.	23e. Did t	obacco use co	ontribute to th	ne cause of death?
g	luires n sigr ld be	q p						1 🗆	Yes 2 No	3 ☐ Prob	pably 4 □Unknown
Ö	w requir been si should	Completed						24a. Was	an 24	b. Were auto	psy findings available
Be	he law e has l	g E						auto perfo	psy ormed?	prior to cor death?	mpletion of cause of
ta	iclan: Th certificate rector, pag		25. Was case referred to medical				26 Place of Do	1□ Yes ath (Check only o	2 No	1∐Yes	2□No
5	ysiclan: The iis certificate ha director, page	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Out	patient 3 DOA Oth	ner.	Home 5 Resi		Other (Specif	····
0	Attending Physician: r death. ector: After this certifics by the funeral director, p	: To	27. Manner of Death	28a. Date of Injury	28b. T	ime of 28c. Inju		28d. Describe			y /
o	nding R th. r: After e funer	tion	1 Matural 5 Pending 2 Accident investigation	(Month, Day	rear) In		rk?]Yes 2 □ No				
Vis.		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc.		m, street, factory, office			Street and Nu wn, State)	mber or Rura	al Route Number,
	s afte	Sert	4 Differnition	building, etc.	(оресну)			Only of 10	Wii, Olale)		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical (examination and	, death occurred at the ti d/or investigation, in my					
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
	6		1/1/1			DO	06498	3	Am:	1 16	2008
,	7		30. Name and address of person who		th (Item 23a) (Type, Print) Medical Pa	/ >	01	<u> </u>	. , ,	1000
			Kathes Friend		2101 1	Medical Pa	nt Dr.	S. Ver	Sprin	5 MD	20910
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar	's Signature	1 4				7	

DHMH 17 Rev 1/2001

Registrar

APR 17 2008

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EMMANUEL OSCI-BOAMAH

MAY 0 1

D0062929

130 Pennsylvania Ave. Cumberland, MD 21502

8-03236		Please Type or Print in Black Indelible Ink. Ens			gible.				
evin C. Bittner		State of Maryland / Department of Health Certificate of Death	and Mental H	lygiene	_ 200	0 11.20			
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Deal	eg.No. 🛴 🕌 💭	3. Time of Death			
ledical Exami		Nevin Clyde Bittner		Month April 27, 2	Day Year 008	0800 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Tow	n, or Location of Deat		4c. County of Death	1			
•		Memorial Hospital Cumber			Allegany				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24Hrs Days Hours Mir	, 	th(MM/DD/YYYY) 9. Bir Foreig	gn			
Bircotor		220-32-4091 1 M 2 F 72 Yrs. Months Usual Residence of Decedent		Augu	1st 10, 1935	Maryland			
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
show and	'n	Maryland Allegany Frostburg				1 Yes 2 No			
Maryll dato	Director	10e. Street and Number 11211 Sugar Row Road. N.W. 10f. Zip Co.		1	0g. Citizen of What Cou	ntry?			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mantal Hygien 72 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once		215			U.S.A.				
ath wir	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puerto		- 14. Race - Amer White, etc.	ican Indian, Black,			
ter de		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 V	No specify:		Specify: V	Vhite			
ours af atural camin	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Oc	cupation (Give kind of		16b. Kind of Business/	Industry			
6 n 72 h an "n ical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ng life. DO NOT use ref	tirea)	state highwa	v dent			
003 within giene.	omp	12 engineer state highway 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)							
21215-0036 uld be filed within 7 Mental Hygienc. marked other than c event, the Medica	Be C	Nevin D. Bittner		V. Twigg	waiden Sumame)				
21.2 ould b d Men s marl ic eve	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address ((Street and Number or	Rural Route Nun	nber, City or Town, State	e, Zip Code)			
MD id 2 sho ilth and in 27 is		Marlene R. Bittner wife 11211 Sugar R		rostburg	Marylan				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Heath and Mental Hygener lant: If item 27 is marked other than or other traumatic event, the Medical		20a. Method of Disposition 20b. Place of Disposition (Name Disposition (Name or Place) 20b. Place of Disposition (Name or Place)		Date	20c. Location - City or				
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other Specify:		pril 28, 2008	Cumberland	Maryland			
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygene. Important: If item 27 is marked other I injury or other traumatic event, the Med		21. Signature of Funeral Service Licensee 22. Name and Ac		57 Frost Av	e., Frostburg, M	D 21532			
Physician		25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of o				Approximate Interval			
'Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Alprazolam intoxication complication)	tine hvoerten	sive ather	rosclerotic	Between Onset and Death			
xaminer		or condition resulting in death) Due to (or as a consequence of): can iovascul	ar disease	DIVE GGR.	CONTRACTOR				
	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				 			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				1			
ted msit	Exa	events resulting in death) Last Due to (or as a consequence of):							
executed an and al - transi	ical	d. X UNPENDED X AMENDED 2/10 27 280-f pormo 8870	D E /00 /00 IIII						
OX 68760, sath certificate be attending physici for use as the buri	cian/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	9 3/29/08 11		23d. Date of deliver	у			
687 Sertific Iding I	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specific	3 Ectopic pregn	nancy	Month	Day Year			
SOX death death e	S.	1 Yes 2 No 9 Unknown 9 Unknown)						
O. E at the	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?			
Division of Vital Records, P.O. Box 68760, within 24 hours after death. Certificate be within 24 hours after death. To the Functor: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Completed by	OOPD, Lung Cancer		1 Yes	s 2 No 3 Pro	bably 4 Unknown			
ords w requ s beer shoul	plete			24a. Was autor	osy prior to	utopsy findings available completion of cause of			
Rec The la cate ha	omo			perfo	rmed? death? 2 X No 1 ✓ Y	es 2 No			
Vital Rec ysician: The his certificate director, page	Be (Place of Death (Check						
of Vid Physic er this	2	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b.	Nursi		Residence 6 Othe	er:			
on of nding Pl tth. r: After	Certification:	(Month, Day, Year)	Yes 2 X No		ingested medic	otion			
Division tal or Attendir safter death.	fica	2 Accident Investigation 3 X Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, of	ffice building, etc.	28f. Location (Street and Number or Ri	ural Route Number, City			
Divinital o	Serti	4 Homicide determined (Specify) house		11211 S	State) ugar Row Rd. F	rostburg, MD			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time control of the contro							
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated. 29b. Signature and title of certifier 29c. L	pinion, death occurred	at the time, date					
	2	1	D.C.M.E.		29d. Date signed (Mo	лш, <i>∪</i> ау, Үеаг)			
		30. Name and address of person who completed cause of death (Item 23a)							
9/			treet, Baltimore,	MD 21201					
S	ate	31. Date filed (Month, Day Year) AND 1 2008 32. Refistrar's Signature							
Regist	1000	MAY 0 1 2008 Shown It work							

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2008 8:12 April 10, Louisa т. Berry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F 79 May 29, Kentucky Director 400-32-0677 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Directo Rockville Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 United States 1003 Nelson Street Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No 2 Specify 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst Federal Government 12 or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Tipton Effie Kennedy 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Spears / Son 20201 County Road 33, Fairhope, AL 36532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 4/21/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate disease or a dittion resulting in eath)

a. Colon Cancer

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** 2 months /Medical Due to (or as a consequence of): Examiner 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiomyopathy Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical for use as the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1☐ Yes 2☐No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Yes funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 2 12 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Vital within 24 hours after death To the Funeral Director: completely

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

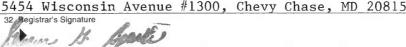
(Check only

one)

Nelson Kalil, M.D. APR 17 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

51616

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

a FOI	aryland / Depa			lental Hygie	ene	0.0	11000
State Registrar	Cei	rtificate of L	Death		. No. 4	UU	14309
1. Decedent's Name <i>(First, Middle, Last)</i> Debra Ann Butler				2. Date of Death	Day	Year	3. Time of Death
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	HPRIX	13 24 4c. County	of Death	0725
Peninsuva Roginal Med	Int Pensa	54	1156414	•	11	can	6
1 I M 2 FE	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear)	9. Birthpl Count	lace (State or Foreign try)
214-76-2089	53 Yrs.		ļ	Nov. 30,	1954	_Del	aware
10a. State 10b. County	10c. City, Town or Lo	cation	,		·	10	0d. Inside City Limits
MD Wicomico		Salisb	ury				tx_xYes 2 □ No
10e. Street and Number		10f. Zip Code		100	. Citizen of V	Vhat Coun	try?
351 Deers Head Hospti		21801	mania Oriaina (On		Wicom	ico e - America	an Indian
Armed Forces? 1 ■ Never Married 2 ■ Married 1 ■ Yes 2 ₹ 1	No IS.	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		k, White,	
3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □ Yes 🎗 🛣 No	Specify:		Specify	Whi	.te
15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d	uring most of work	ing 1	b. Kind of Bu	usiness/Ind	lustry
Elementary/Secondary (0-12) College (1-4or 5	i+)	DO NOT use retired) / A			N/A		
17. Father's Name (First, Middle, Last)	14 /		18. Mother's Name	e (First, Middle, Ma		ne)	
Franklin Leon Butler			Anna Ma	e Kelle	v But	ler	Rotherme1
19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a	nd Number or Aur	al Route Number, (City or Town,	State, Zip	
Anna Mae Rothermel/Moth		histlewood					
20a. Method of Disposition 1x → Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren		1		c. Location -	,	,
4 Donation 5 Other (Specify)	Odd Fell	ows Cemet	ery 04/1	7/08 S	eaford	, Del	aware
21. Signature of Funeral Service Licensee Michael 7 - Casking	F	2. Name and Addres	Fran Fran rg, MD 21	nptom Fun 1632	eral H	ome,	P.A.
23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lit	the death. Do not entented.	er the mode of dying	, such as cardiac	or respiratory arres	t,		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death) a	SCVD						Onset and Death
Due to (or as	a consequence of):						
Sequentially list conditions, if any, leading to immediate b. Due to (or as	a consequence of):					_	
if any, leading to immediate cause. Enter Underlying Cause, Disease or in jury that initiated events							
	a consequence of):						
d							
IF FEMALE: 23b. Was decedent property 23c. If yes, outcome	of pregnancy				004 04	a at deller	
in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)				te of delive nth	Day Year
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown							
Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use cont	ribute to th	e cause of death?
Unny fract intert	- W sees	C1.		1 ☐ Yes	2 No	3 Prob	ably 4 □Unknown
1 typs tu-				24a. Was an autopsy	24b. \	Were autoporior to con	psy findings available inpletion of cause of
				performe	ed? c	death?	2□ No
25. Was case referred to medical examiner? Hospital:		othe	,,	h (Check only one)			
1 Yes 2 No 1105phai. 1 Inpatie 27. Manner of Death 28a. Date of Inju		00000	4 Li Nursing Ho	me 5 Residen			2
1 ☑ Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	<i>Year)</i> Injury	f 28c. Injury Work M 1 □ Y	es 2 No		,,	-	
S Could not be	ury - At home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Numb	er or Rura	l Route Number,
Sullang, or				Only or Youn,	otate)		
29a. Certifier (Check only one) 1 Tertifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the cau red at the time, dat	se(s) and ma e and place,	anner as st and due to	ated. the cause(s)
29b. Signature and title of certifier		29c. License			I. Date signed	d (Month, I	Day, Year)
1 h w he		(1	10 T617-	7	4/13	12	
30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print)	1 52	Sol. 5	ns	218	ツ
31. Date filed (Month, Rap Year) 4 2008 32. Resetr	ar's Signature	And					

ORIGINAL

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month **Physician** 16, 11:45A M Donald Fairchild Byrd April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1X M 2□ F Days Hours Director 227-60-0905 1946 61 July 4, Washington, D.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinant rust be multipled at 1 ☐ Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7996 Brightlight Place 21043 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2X No 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Manager</u> <u>Freight Company</u> Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ William Orval Byrd Ruby Frances Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st.
Department of Health anc
Important: If item 27 is n
any injury or other traun Phyllis Leigh Byrd/wife 7996 Brightlight Place Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 04/18/08 Beltsville, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Khabdomy o sarcomA months /Medical Due to (or as a consequenc of): Examiner Sequentially list conditions Examiner it any leading to inmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence offg physician and as the burial-trans Due to (or as a consequence of): Box 68760 that the death certificate be Physician/Medical attending ase If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.0. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 2 De No certificate of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XDther (Specify) WSSPICE 1 ☐ Yes 2 🙀 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1. Natural 5 Pending ithin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

ECTI

J-JOhn

April16,2008 11

31. Date filed (Month, Day, Year) APR 1 8 2008

6701 32. Reistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Plassa	Type or	Print in	Black	Indelible lnk.	Ensure A	II Copies	Are Legil	ole
Piease	i ype oi	FIIIIL III	DIACK	machbie mik.	Lilouio			

obert Edward Boo		Jr. For State	State	of Maryla	nd / Depa	rtment of tificate of	Health a Death	and Me	ental Hyg		. No.	20	00 1	1,3
Division	_	gistrar Decedent's Name (Fire	st. Middle.Las	t)				· · · · · ·	2	. Date of Death		Year	3. Time of Death	
/Physician اوران 'Examine		Robert Edwa								Month April 22, 20	08		1925 hrs	
Č.	4:	a. Facility Name (if not	institution, giv	e street and nu	mber)	4	b. City, Towr	, or Location	on of Death		1	nty of Death Arundel		
	ı	8062 Telegraph	Road				Severn			D C - F Dist		_	place (State or	
Funeral	1	Social Security Number		ex	7. Age (In yrs. I	ast birthday)	If Under 1 Months		nder 24Hrs. ours Min.	1		Foreign) m4== 1\	ļ
Director	12	216-72-4537	182	XM 2 F	3.	5 Yrs.				11/4/1	972	Cou	MD_	
>		sual Residence of Dec	edent County		10c City	Town or Locati	on				_		10d. inside City l	imits
) w a n y			Anne A	rundol		Severn							1 Yes 2X	X No
Aaryland Aaryland 1 at once.	<u> </u>	MD Oe. Street and Number		Lunder		Severn	10f. Zip Co	de		10	g. Citizen o	f What Coun	try?	
or 28s	[]	8062 Teleg		D .				21144				USA		
r death with the Maryland or items 23a or 28a-f sho	1	1. Marital Status	Lupii id	12. Was Dec	cedent Ever in U	I.S. 13. Wa	s Decedent o	f Hispanic		ecify Yes or No-			can Indian, Black,	
eath v		1 Never Married	2 X Marrie	Armed F	orces?					(ican, etc.)			. _	
s after of right, or niner m		3 Widowed		d If Yes, Give Yes or Dates:		1 16a. Deceden	Yes 2 X			ork dono		ify: Whit		
natur Zxami		15. Decedent's Educa				16a. Deceden during m	ost of workin	g life. DO N	NOT use retire	ed)	lob. rang c	, Baoirrecorn	,	
36 in 72 in 72 ilical J		Elementary/Seconda	ry (0-12)	College (1-4 or 5+)	Const	ructio	n			l B	uildi	ng	
5-0036 ed within 72 hours lygiene. other than "natu he Medical Exan	┋┝	12 17. Father's Name (Firs	t, Middle, Las	t)		1 001100			other's Name	(First, Middle, N				
215 be file mtal Hy rked o		Robert E.	Bock S	R.					un Bow					
21 could be mar	2 [7	19a. Informant's Name/								ural Route Num			, zip Code)	
MD id 2 sh lith an m 27 i	- 1	Daun Bowie		m Mot		Place of Dispos	Killa Sition (Name			Jnion, K		.091 tion - City or	Town, State	
ore, of Hea of Hea of Hea		20a. Method of Disposi	tion Cremation 3	Removal	from State	crematory or of	her place)			06/2000	C1 am	Dansen	ia MD	
Page ment tant:	1	4 Donation 5			GI	en Have:				26/2008 desty I			ie, MD	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merlal Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	И	21. Signature of Funera	al Service Inc	ensee						napolis			5, 1.A.	
Physician	+	23a. Part I. Ent the di	isease, or con	nplications that	caused the deat	th. Do not enter	the mode of	tying, such	as cardiac o	r respiratory arr	est, shock,	or heart	Approximate I Between Ons	
ledical.	-1	failure. List only	ne cause on	each line.		on and co							Death	
	-	Immediate Cause (Fina or condition resulting it			a consequence						_			
		Sequentially list condit		b	a consequence	of):								
	<u>=</u>	if any, leading to imme cause. Enter Underlyi	ng Cause	c.	a consequence									
	za	(Disease or injury that events resulting in dea		Due to (or as	a consequence	of):								
0, e be executed ysician and burial - transit	dical Examine	- INDENDED		d			/ -							
	ΨF	X UNPENDED			7,18a-f, s, outcome of pro	perME,g87	9, 5/6/	08 TT			23d. D	ate of deliver	ry	
Box 68760 e death certificate bette attending physical for use as the brown and the brown as the	[]	IF FEMALE: 23b. Was decedent pre past 12 months?	gnant in the	1 Live	e birth	2 🗌 F	etal death	3 E	ctopic pregna	ancy	Mo	onth	Day Ye	ear
ox 6 th cer ttendi	띯	1 Yes 2 No	9 Unkno		gnant at time of	death 5 (other (Speci	y)						
BO) he death y the att	Physician/M	Part II. Other signification		3 0116	to death but no	ot resulting in the	underlying	ause given	in Part I.	23e. Did 1	obacco use	contribute to	o the cause of de	ath?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	6	Tare in outloo organis								1Ye	s 2 🗸 N	o 3 Pro	obably 4 Un	known
ords, w require	Completed									24a. Was		24b. Were a	autopsy findings a completion of ca	vailable use of
COF	힑	k ——									ormed?	death?		No
Vital Rechysician: The Inthicute of the certificate Intercept, page		25. Was case referred	to medical	T			2	.Place of [Death (Check					
Vital ysician: his certif director,	8	examiner?		Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 D	Oth	er. 4 Nursi	ng Home 5	Residence	e 6 🗸 Oth	er: Scene	
ing Phy After th funeral d	의	1 ✓ Yes 2 27. Manner of Death	INO	28a. Da	ate of Injury onth, Day,Yeer)	28b. Time o	f Injury 2	3c. Injury at		28d. Describe	how injury	occurred		
on cadin ath.	ţi		5 Pendin Investig	g Fnd	4/22/2008	3 Fnd 7:1	.5 pm	1 Yes	Λ	unk				0'4
visi or Att fler de in by	ifica		y Could	not be 28e. Pl		t home, farm, st		office build	ling, etc.	28f. Location or Town,	(Street and State)	Number or I	Rural Route Numl evern, MD	ser, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide	determ	(Op.co.		l in house								
FE 241	edical	29a. Certifier 1 C (Check only one) 2 M	ertifying Phy edical Exami	sician: To the t mer:On the bas	best of my know is of examinatio	ledge, death occ on and/or investi	curred at the gation, in my	time, date a opinion, de	and place, an eath occurred	at the time, dat	e and place	, and due to	the cause(s)	
To the comple	Medi	29b. Signature and tit		and manne	er stated.	-		License n					Month, Day, Year)	
LR-	_	2	nu li	n. 1.	MD-			O.C.M.I	E.		April :	23, 2008		
21/60		30. Name and addres	s of person w	no completed o	ause of death (I	tem 23a)								
Dex		Donna M. Vir		Assistan	t Medical Ex	xaminer 1	11 Penn	Street, B	altimore, l	MD 21201				
	ate	31. Date filed (Month,	Day, Year)	o 2nna 32.	. Registrar's Sig	nature	1.0							
Regist	rar		HPK Z	8 2008	pertue	, JU	The same							
DHMH 17 Rev 1/20	001			0010	-1	ORIGIN	IAL							

1-	For State Registrar
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			for State Registrar	01410 01 1114	· y · a· · · a	Cei	rtificate of	Death		Reg. N	2008	14312
1.5	Physicia	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of D Month		ay Year	3. Time of Death
	/Medic		Bernard Augusti						Apri	<u> 2</u>	8 2008	10:30 A M
	Examin	er	4a. Facility Name (If not institution, give					r Location of Death			c. County of Deat	h
			700 west Bel Air 5. Social Security Number 6. S	4.	t. 120		Aberdee		8. Date of B		Harford	hplace (State or Foreign
,	Funeral Director			M 2 ☐ F	71	Yrs.	Months Days	Hours Min.	1/13/	a <i>y, Yea</i> 1937	r) Co PA	untry)
	land ow at		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Mary -f sh	호	MD Harfo	rd	Ζ	berd	leen					1 XYes 2 ☐ No
	h the or 282 o noti	Funeral Director	10e. Street and Number				10f. Zip Code			10g. C	citizen of What Co	untry?
	th wil	a	700 West Bel Air	Ave. Apt.	120		210	001			U.S.A.	
	r dea	nel	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	1 ☐ Never Married 2√2 Married 3 ☐ Widowed 4 ☐ Divorced	1 X]Yes 2 □ N If Yes, Give Year or Dates: K (orea		1 □ Yes 2 X No	Specify:			Specify: Wh	ite
ה ה	72 h 'natu dical	Completed	15. Decedent's Ed (Specify only highest gra		16	Ba. Deced (Give	dent's Usual Occup kind of work done	oation during most of word d)	king	16b.	Kind of Business/	Industry
V	within ene. than '	ldm	Elementary/Secondary (0-12)	College (1-4or 5+				a)				
V	Hygie Hygie ther t	ပ္တို	17. Father's Name (First, Middle, Last)	2		Nurs	e	18. Mother's Nam	ne (First, Middle		edical en Surname)	
ומוני	uld be intental rked o	To Be	James Bernard C						id Jone		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Mary	2 shou and N is ma auma		19a. Informant's Name/Relationship (**				and Number or Ru				Zip Code)
≥	and lealth m 27		Beth Coogan (Sp	ouse)			Maxa Road		deen, M	-	21001	
5	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐	Removal from State			sition (Name of matory or other pla	1	Date	20c.	Location - City or	Town, State
Dallillo	t. Pa rtmen rtant: njury		4 Donation 5 Other (Specifical Signature of Funeral Street Light		R. A.		ris & Co. Name and Addre		/08	Wes	t Cheste	r, PA
0	permi Depar Impor any Ir		21. Signature of Funeral Source Liger	-m12.		2		g-Cargo F en, Maryl	uneral	НОТ	e, PAA.	
	В		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. D	o not ent					-3399	Approximate
	Physician		Immediate Cause (Final	one cause on each line		11	>					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	ce of):						171
	Examiner		Someonially list conditions	b								
	Sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	ecute and I-trans	xam	that initiated events resulting in death) Last	c Due to (or as a	consequenc	e of).						-
00/00	be eg	aE			, , , , , , , , , , , , , , , , , , , ,							
000	ritificate be executed ng physician and s as the burial-transit	Medical		_d								
O. DOX	The law requires that the death cert ate has been signed by the attending agge 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 months? ☐ No ☐ No ☐ No ☐ No ☐ No ☐ Under Superior 2 Petal death 3 Declopic pregnancy 5 Dother (specify)							23d. Date of del Month	ivery Day Year
Ľ	that the ed by detac		Part II. Other significant conditions of	ontributing to death but	t not resulting	g in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
cords,	quires in sign uld be	d by	COPD						.12	Yes	2 □ No 3 □ Pr	obably 4 □Unknown
5	aw re Is bee 2 sho	Completed	AODN	1					24a. Wa		24b. Were au	utopsy findings available completion of cause of
č	The I	mo							per	opsy formed? 2 2 1	death?	
פ	ctor,	Be C	25. Was case referred to medical examiner?					26. Place of Dea				
5	hysik this o	2	1 Yes 2 No		nt 2 ER/			4 L Nursing n			6 □Other (Spe	cify)
	ting F	ion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Ye ar) 28t	o. Time o Injury	Wor	ryat rk? Yes 2∐No	28d. Describe	how in	jury occurred	
2	Attenc death ctor: y the	icat	3 Suicide 6 Could not be		ry - At home,	farm, str		1 tes 2 🗆 1 NO	28f. Location	(Street	and Number or Ri	ural Route Number,
2	s after al Dire	Certification:	4 Homicide determined	building, etc.	(Specify)				City or To	òwn, Sta	ate)	,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (29a. Certifier (Check only one)	ysician: To the best o niner: On the basis of and manger stat	examination	ige, deat and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to thurred at the time	e cause e, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	To th withir To th сотр	Me	29b. Signature and title of ortifier)	>	29c. Licens	se number		29d. D	Date signed (Mont	h, Day, Year)
			1///	yar	//		1)	2260	27	4	108	18
			30. Name and address of person who	completed eause of de	ath (Item 23a	a) (Type	Print) On	m. m.	10 1	50		0
	Cto	to	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	784	11/18	Service	Le K		1110	<i>//</i>
	Sta Registr		MAY 0 1 20	200	B	90	342	P	reer	n	2113	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medica Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the buriat-transit Division or Vital Records, P.O. Box 68760,

Physi

Exam

Funera Directo

	1 - State Registrar		,		rtificate of		aria ivici	ntal Hyg	leg. No.	08	431
	1. Decedent's Name (First, Middle,	, Last)					2.	Date of Dea		· · · · · ·	3. Time of Dear
ian	STEVEN	R		CA	RR		A	Month PRIL	26, 200	8 Year	6:50A
cal ner	4a. Facility Name (If not institution,	, give street and number	er)		4b. City, Town	or Location of	of Death		4c. Count	ty of Deat	h
(A)	FREDERICK MEMO	DRIAL HOSPI	TAL		FREDEF	RICK			FRE	DERI	CK
	5. Social Security Number		Age (In yrs. I	last birthday)	If Under 1 Yea			Date of Birth (Month, Day	Year)	9. Birt	hplace (State or For
	215-84-0197	1 X M 2 □ F	46	Yrs.	WOTHING Day	s Hours			, 1961		yland
	Usual Residence of Decedent		100 Cit	y, Town or Lo	action						10d Incide City Lin
_	10a. State 10b. County										10d. Inside City Lir 1 1 Y Yes 2 □
cto	3	erick	F	rederi							
Director	10e. Street and Number	1 D			10f. Zip Code				10g. Citizen of		ountry?
<u>a</u>	999B Heather Ri				2170				USA		
Funeral	11. Marital Status	12. Was Decede Armed Force	es?	S. 13.	Was Decedent of If Yes, specify Co	Hispanic Ori Jban, Mexicar	n, Puerto Ric	/ Yes or No- an, etc.)	Bk	ack, White	erican Indian, e, etc.
by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed 1 Tes 21 If Yes, Give Year or Date	K. 140		1∐Yes 2 X N	o Specify:			Spec.	ify: W	hite
ba	15. Decedent			16a. Dece	dent's Usual Occ	upation		Ī	16b. Kind of I	Business/	(Industry
Set	(Specify only highes	t grade completed)		i (Give	kind of work dor DO NOT use reti	e durina mos	t of working	ï			,
Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		ce Stati	,	endan	t	Gas S	tatio	on
	17. Father's Name (First, Middle, L	Last)		1		18. Mothe	er's Name <i>(F</i>	irst, Middle,	Maiden Surna	ame)	
To Be	John Harvey C	Carr				Eli:	zabeth	. Ann	Pend1	Leton	1
-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Stre						
	John Harvey Car			13626	Daisy	Circle	, Hage	rstow	n, Marv	/land	1 21740
1	20a. Method of Disposition	•	20b. P	lace of Dispo	sition (Name of	- :	Date		20c. Location		
	1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 🖋 ☐ Other (Sp		ate l	-	matory or other p Heaven		Mr. 30	. 2008	Silver	Spr	ing, MD
	21. Signature of Funeral Service)		- July		2. Name and Add				Main		
	1/1/6	2/_			icketts						D 21773
	23a. Part1. Shter the dis as	omplications that caus	sad the death							c, m	Approximate
	shock, The art fail e. List of Immediate Cause (Final	only one cause on each	h line.	-							Interval Between Onset and Death
	disease or condition resulting in death)	a			VEU.	MON	MA				DAYS
	,,	Due to (or	as a consequ	uence of):							
	Sequentially list conditions,	b. Due to /or	as a consoni	uonco of\:							
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I C	Cause (Disease or injury that initiated events										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2008 1:00 P M Dorothy Evelyn Coffman April 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 17542 Sabillasville Road Sabillasville Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 1, 1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Maryland 1 □ M 2 F Months Days Hours Min. 98 214-16-1991 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 No Maryland Frederick Sabillasville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17542 Sabillasville Road 21780 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No White Specify: 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mill Worker Knitting Mill 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Leeslie Buchanan Clara Etters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Grail/Great Niece 17542 Sabillasville Rd., Sabillasville MD, 21780 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Blue Ridge Cemetery 4/17/2008 Thurmont, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stauffer Funeral Home 104 E. Main Street, Thurmont, MD 21788 ximate al Between and Death

Physician /Medical **Examiner**

physician and the burial-transit

attending pl

director,

The law requires that the death certificate be executed

Attending Physician:

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical certificate has been signed by the rector, page 2 should be detached Be P To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Certification:

Medical

23a. Part1. Enter the disease, or o shock, or heart failure. List of	complicat	ions that caused the death. Do not enter the mode of dying, such as cardiac cause on each line.	or respiratory arrest,		Appro Interva Onset
Immediate Cause (Final disease or condition resulting in death)	a . −	Atrial Fibrillation Due to (or as a consequence of):			Onset
Sequentially list conditions, if any, leading to immediate cause. Enter the remarkable of the cause (Disease or injury that initiated events	b. =	Due to (or as a consequence of):		S	
resulting in death) Last	d	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c.	If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify)		23d. Date of de Month	elivery Day
Part II. Other significant conditio	ns contrib	outing to death but not resulting in the underlying cause given in Part I.		o use contribute t 2 X No 3 □ P	to the caus
			24a. Was an autopsy performed? 1□ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	? d <u>ea</u> th?	completio

e of death? 4 Unknown dings available n of cause of 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hornicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1/mer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

State Registrar

31. Date filed (Month, Day,

John Farmer

32. Registr, 6 2008

Roadside Avenue, Waynesboro, PA 17268

State of Maryland / Department of Health and Mental Hygiene amend #5 Per FH G879 5/08/08 Per IIII Cate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Donna Jean Carter 10:38 AM 17, 2008 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline Federalsburg 3649 Houston Branch Road 8. Date of Birth (Month, Day, Year) Nov. 7, 1949 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. **214**5-54-6731 **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 58 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☐ No Federalsburg Director MD Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be ≀ 21632 United States 3649 Houston Branch Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Eventione. 1 ☐ Never Married 2 € Married White 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify. Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transport & Storage Co. Customer Service Rep. G.E.D. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Alberta McQuay Stonewall Jackson Kiser ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type, Print) Russell E. Carter, Jr./Spouse 3649 Houston Branch Road, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Cambridge, Maryland Mid-Shore Cremation 04/21/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Framptom Funeral Home, Federalsburg, MD 21632 216 N. Main St., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Immediate Cause (Final disease or condition resulting in death) ancer cano years **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy perform or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 2 No ို 1 ☐ Yes 2 ER/Outpatient this nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🖟 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 47357 04-18-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton, MO 21601 Dr Anne Gradu ea 31. Date filed (Month, Day State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1050 M Collison James Dawson 4 15 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Easton Talbot Hospital Memorial 8. Date of Birth (Month, Day, Year) Jan. 4, 1920 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. Maryland 1 XM 2 ☐ F 212-18-6030 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State other than "natural", or items 23a or 28a-f show vent, the Medi-al Examiner must be notified at 1 ☐ Yes 2 🙀 No East New Market Director MD Dorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21631 5633 Beach Haven Road by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: WWII and 2 should be filed within 72 hours after lealth and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) state hospital steam fitter 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Rhodes Dawson Collison ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 5434 White Hall Road, Cambridge, MD Linda Robinson daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages
Department of I
Important: If Ik
any Injury or o 1 N Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 4/18/08 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. = k.-700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Assiration Haona 10 minutes **Physician** disease or condition resulting in death) /Medical Du (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Maturai 5 ☐ Pending investigation within 24 hours after deam.

To the Funeral Director: At 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier FA 00 29858 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Street Easton, MD 21601 219 5 Daniel trar's Signature 32. Re 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** April 2008 20 Elizabeth Emma Codrington 1335 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 all of

9. Birthplace (State or Foreign Country) Memorial Hospital at Easton aston

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Social Security Number **Funeral** Months 1 □ M 2 ☑ F Director 126-32-2796 March 21, 1913 New York Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location a or 28a-f show t be notified at 10d. Inside City Limits Maryland 1 ☐ Yes 2 ☑ No Director Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Inter 27 Is marked other than "natural", or items 23a or: ral", or items 23a Examiner must b 410 Colonial Drive United States of America
o- | 14. Race - American Indian, 21629 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑tNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 Specify: Caucasian 3 AWidowed 4 ☐ Divorced Completed er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Senn Louis Sarah Trenchard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 122 South Harrison Street,

20b. Place of Disposition (Name of cemetery, crematory or other place) Richard C. Codrington Easton, Maryland
20c, Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important; If Ite
any injury or ot
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capital Crematory 4/ 4/21/2008 21. Signature of Funeral Service License Jan Cople Moore Funeral Home, P.A. Denton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Die to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be execute burial-trar Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 **N**o To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29c. License number 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 00053255

State Registrar

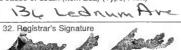
31. Date filed (Month, Day, Year)

Melinda

APR 2 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Butter





2008

Preston MD 21655

20b. Place of Disposition (Name of cemetery, crematory or other place)

Price-Wesleyan Cem.

22. Name and Address of Facility

Physician /Medical

permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr

Baltimore, Maryland 21215-0036

Examiner

	Immediate Cause (Final disease or condition resulting in death)	a Stroke	, .				Onset an	d Death
ical Examiner	Sequentially list conditions, if any, leading to framediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Sey the Land to (or as a consequence of the cons	Dreas	Jain		-	3 we	ehs.
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	al death 3 □Ectopic			23d. Date of de Month	l blivery Day	Year
ed by Pr	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacco 1 ☐ Yes	use contribute t		
Complet					24a. Was an autopsy performed?	prior to death?	utopsy finding completion of	s available cause of
Be	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)			
0	1 ☐ Yes 2 No	Hospital: 1 Minpatient 2 □	ER/Outpatient 3 1	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Spe	ecify)	
ation:	27. Manner of Death 1 Matural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju			
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fact fy)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Fi te)	lural Route No	ımber,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ģ this within 24 hours after death To the Funeral Director: filled in by the

Division or Vital Records, P.O. Box 68760,

v occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

04/23/2008 Little Orleans, MD

141 West Main Street

Grove Funeral Home, P.A. Hancock, MD 21750-0368

11745 Big Pool Road Clear Spring, MD 21722

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16 AD HIKKUTOWN SHARAUN 1190 Mr 31. Date filed (Month, Day, Year)

State Registrar

Medical

19a. Informant's Name/Relationship (Type. Print)

Virgil E. Creek/Husband

3 ☐Removal from State

1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify)

21. Sonature of Juneral Service Licensee

20a. Method of Disposition

32. Registrar's Signature

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	arylan		artment of rtificate of				giene Reg. No.	2008	14319
	Physici	on	1. Decedent's Name (First, Middle,	Last)						2. Date of De	ath Day	Year	3. Time of Death
Mary.	-/Medic		Sarah Ann	Dungan						April_	14	, 2008	10:00 a™
12.5	Examir	ner	4a. Facility Name (If not institution, g	· · · · · · · · · · · · · · · · · · ·			4b. City, Town		n of Death			County of Death	
			199 Rollins Av 5. Social Security Number 6		ie (In vrs	last birthday)	Rocks If Under 1 Year	ville r ⊟fUnde	er 24 Hrs.	8. Date of Birt		Montgome	
	Funeral Director		508-42-2734 Usual Residence of Decedent	1 □ M 2 🔀 F		0 Yrs.	Months Day		Min.	8. Date of Birt (Month, Da)ec • 20	y, Year) , 193	37 Neb	place (State or Foreign ntry) raska
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Many a-f sh ified	ţo	Maryland Montgo	mery		Rockvi	11e						1 X Yes 2 No
	or 28,	Director	10e. Street and Number	.		,	10f. Zip Code				10g. Citiz	zen of What Cou	ntry?
	th wi	la [199 Rollins Av	enue #509			208	352			Un:	ited Sta	ites
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene, them "natural", or items 23a or 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of If Yes, specify Cu	Hispanic C ban, Mexic	Origin? (Spe an, Puerto F	cify Yes or No Rican, etc.)	- 1	 Race - Ameri Black, White, 	
36	rs afte		1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ ! If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🖾 N	Specif	fy:			Specify: Wh:	ite
8	2 hou atura cal E	ted t	15. Decedent's	Education		16a. Dece	dent's Usual Occ	upation			16b. Kir	nd of Business/Ir	
21215-0036	thin 7; e. an "n Medi	Completed by	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	5+)	(Give life.	kind of work dor DO NOT use reti	e during mi red)	ost of workir	ng			
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7	12 should be find and Mental H	٩	Warren Willo 19a. Informant's Name/Relationship		is .	19b Mailir	na Address (Stre			Rachel		omas r Town, State, Zi	n Code)
<u>≅</u>	and 2 s ealth ar n 27 Is ier trau		Harold Elmer Du	,	100		•					e, MD 20	,
ē,	s 1 and 2 if Health item 27 other tra		20a. Method of Disposition				sition (Name of matory or other p			ate		cation - City or T	
Ë	Page nent o int: if		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				ln Crem	1	4/16/	2008	Bre	ntwood,	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lic	censee			. Name and Add			mple T			TID
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused ly one cause on each li	d the death ne.	n. Do not ent	er the mode of d	ying, such a	as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Caus (Final disease or condition resulting in death)	a. Breast									6 months
	Examiner			Due to (or as	a consequ	uence of):							
6.		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	uence of):							
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	± o ĕ	/Me	IF FEMALE:	23c. If yes, outcome	pf pregna	incv						23d. Date of deliv	op.
Box	death cer e attendin ed for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1□Live birth 4□Pregnant al	2 Feta	Ideath 3□	Ectopic pregnar Other <i>(specify)</i>	ıcy			-	Month	Day Year
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S, P	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	s contributing to death b	ut not resu	ulting in the u	nderlying cause	jiven in Par	t I.			se contribute to t	the cause of death?
or Vital Records,	w requir been si should									10	Yes 25	No 3□ Pro	bably 4 ☐Unknown
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al F	ician; The certificate ha			-						1 Yes	rmed? 2 ☑ No	death? 1 ☐ Yes	2□ No
Κ		Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	0.0	ER/Outpatier	at 3□ DOA C	Ale		(Check only o			
	g Physer this eral di	٦: ٢	27. Manner of Death	28a. Date of Inju	ıry	28b. Time o	I 3 DOA	4 🗔 !		8d. Describe I		Other (Speci	fy)
ion	Attending Frideath. ector: After	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat		y Year)	Injury		ork? ⊒Yes 2[□No				
Division	or Atten after deatl Director: in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At ho	me, farm, str	eet, factory, offic	е	2	8f. Location (5 City or Tox			al Route Number,
	urs a												
	e Hospital or, 24 hours after e Funeral Dire letely filled in b	Medical	29a. Certifier 1. Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examina	wledge, deat tion and/or in	n occurred at the vestigation, in m	time, date opinion, d	and place, a leath occurre	and due to the ed at the time,	cause(s) date and	and manner as a place, and due	stated. to the cause(s)
	To the Hosp within 24 hou To the Fune completely fi	Mec	29b. Signature and title of certifier	and manner St	aiou.	Commen	29c. Lice	nse numbe	r		29d. Date	e signed (Month,	Day, Year)
	6		× 1/4 0	Alenn	Novi	97	D50	378			/, / 1	15/2008	
7	D		30. Name and address of person wh	no completed cause of d	leath (Item	23a) (Type,		370			→/ 1	27/2000	
			Cherly A. Ayles				versity	Blvd.	W. S	te.400	, Whe	aton, M	D 20902
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 7 2	32 Registr	ars Signa	ture	well						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 16, 2008 1:25 A.M Corinna DiGiulian April 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 415 Russell Avenue, # 409 Montgomery Gaithersburg 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🛛 F Days 579-60-5975 97 Feb. 16. 1911 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1

Yes 2

No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Russell Avenue, # 409 20877 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph DiGiulian Crystofana Castalina 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Marie DiGiulian/Sister 415 Russell Avenue, # 409, Gaithersburg, MD. 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 4/17/2008 Washington, DC 21. Signature of Funeral Service Lic 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

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Completed

Be

Funeral

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

burial-transil and

the

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	Immediate Cause (Final disease or condition resulting in death)	a Chronic Kidney Disease		Onset and Death Years								
	resulting in death)	Due to (or as a consequence of):										
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Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X□No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown											
	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?								
Q D	Hyperlipidemia,)iabetes	1 ☐ Yes 2% No 3 ☐ Pr	robably 4 □Unknown								
Completed by	24a. Was an autopsy performed? 1□ Yes 2 ☑ No 1□ Yes											
Re	25. Was case referred to medical examiner?	26. Place of Death ((Check only one)									
examiner? 1 Yes 2 No												
ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred									
Sertification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Ru City or Town, State)	ural Route Number,								

1KI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 41794

29d. Date signed (Month, Day, Year)

April 16, 2008

Registrar

State

Priscilla Callahan-Lyon, M.D.,911 Russell Avenu, Gaithersburg, MD. 20879 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only

APR 17 2008



leted cause of death (Item 23a) (Type, Print)



08-02870 Ian Dolensek Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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2	U	U	U	1.1	J	La

		- For State Registrar		Certi	ificate of	Death				Reg. No		. U U	0 1432
Physicia	n/	1. Decedent's Name (First, Middle,Last Ian M. Dolens						1	2. Date of Death Month Day Year April 12 2009 1345 hrs				
ledical Examin		Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Division of					of Death	April 12, 2006					
		162 Prince Georges Street				Annapolis				Anne Arundel			
Funeral		5. Social Security Number 6. S	ex 7. Age (in yrs. las	t birthday)	If Under 1 Y			15				
Director		073-64-0949	M 2 F	41	Yrs.	Months D	ays Hours	Min.	May 3	31, 1	1966	Foreign Cour	ntry) Michigan
	Usual Residence of Decedent							_					10d. Inside City Limits
ow any		10a. State 10b. County Maryland Anne A	c. City, I	own or Location	on	Annap	olis					1 X Yes 2 No	
rfaryland 28a-f show d at once,	흵	10e. Street and Number 10f. Zip Code 10							10a, Ci	tizen of Wh			
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Director		e George Street			21401						S.A.	
with t		I											an Indian, Black,
death w	Funeral	1 X Never Married 2 Married	No					Rican, etc.)		White			
s after ral",	ᆰ		If Yes, Give Year or Dates:	-11		Yes 2XX			. dono	1165	Specify: Kind of Bu	Whi	
2 hour "natu	밁	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)			t's Usual Occu ost of working							
136 thin 7 re. than	ompleted	, , ,	1		1	Manager	0			ŀ	Iospit	alit	У.
5-0 lled wi Hygie I other	ပ၂	17. Father's Name (First, Middle, Last Emil Dolensek			18. Mother's Name (Fi				e, Maide	n Surname)		
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat c event, the Medical Exa	a a	19a. Informant's Name/Relationship (10h Mailing	Addross (C)			Moen	oute Number, City or Town, State, Zip Code)			
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than ther traumatic event, the Medical	٤	Nancy Shanley/m			*	Prince					-		
Tore, MD 2 ages I and 2 should of Health and N. It. If item 27 is nother traumatic	ŀ	20a. Method of Disposition			ace of Disposi	ition (Name of			Date				Town, State
nor ages ant of nt: If		1 Burial 2 X Cremation 3 4 Donation 5 Other Specify	the same of the sa		ematory or oth timore	Cremat	orv	4/15	5/2008	Ba	ltimo	ore.	Maryland
Baltimore, permit. Pages I as Department of He Important: I fite Important: or other to the Injury or other to the Important.	t	21. Sign lette of Fun ral ervice Lice	19-2-17					y Joh	ın M.	Tayl	or Fu	ınera	il Home
a 50 E it	-	Joan E	pulle)	14	7 Duke	of Glo	ouces	ster S	st.,	Annar	olis	, MD 21401
Physician 'Medical		23a. Part I. Enter the disease, or com failure. List only one cause on e	ach line.						respiratory	arrest, s	hock, or he	art	Approximate Interval Between Onset and
xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)	Gastrointestinal Due to (or as a consequ			o cirrhosis	of liver		_			-	Death
		Sequentially list conditions,		301100 017									
	Ĭį.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	uence of)									
_ =	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):										
		d	d										
760, icate be execute physician and the burial - tran	Physician/Medical	UNPENDED	AMENDED	of neone	2004					23d. Date of delivery			
18760, rtificate be ing physic as the bur	<u>₹</u>	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 2 2 2 2 3 3 3 3 3 3											
Box 68 c death certifi the attending cd for use as	Sici	1 Yes 2 No 9 Unknow		nant at time of death 5 Other (Specify)									
D. B. at the de by the ached f	튑		ns contributing to death but not resulting in the underlying cause given in Part I.					art I.	23e. Did tobacco use contribute to the cause of death?			he cause of death?	
1 Yes 2						2 ✔ No 3 Probably 4 Unknown							
rds, requir been s	etec									Was an autopsy findings available prior to completion of cause of			
The part of the pa								performed? death?					
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical				26.PI	ace of Death	(Check c				V	
Vita hysicis this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2	ER/Outpatient	3 DOA	Other ₄	Nursin	Home 5	Resi	dence 6	✔ Other:	Scene
n of V	آڃَ	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Yea	r)	28b. Time of I		njury at Wor		28d. Descr	ibe how i	njury occur	red	
Sior Mitend death ctor:	<u>ĕ</u>	2 Accident 5 Pending Investiga					Yes 2		206 L ===ti	- /Ctros	t and Numb	or or Du	ral Pauta Number City
Division ospital or / hours after uneral Dire	ertification:	3 Suicide 6 Could no determine		y - At noi	me, rarm, stree	et, ractory, ome	e bullaing, e	stc.		n, State)		iei or Rur	ral Route Number, City
Hospit 24 houn Funer ely fill	ပြ	4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
Division To the Hospital or Attent within 24 hours after death To the Foueral Director: completely filled in by the	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
F S F O	ž	29b. Signature and title of certifier	W.				ense numbe	_					nth, Day, Year)
		Mayone 1	me Brel	o.c.m.E.				April 13, 2008					
		 Name and address of person who Margarita Korell MD. A 	completed cause of dea			enn Street	Baltimor	e. MD 2	21201				
Sta	te	•											
Registi	ar	31. Date filed (Month, Day, Year) APR 16 2	108 Eleve	1	X And	Me -							

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

To Be (17. Father's Name (First, Middle, Last Shade Fisher	9		18. Mother's Name (A Edna Hi		en Surname)			
-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Street	and Number or Rural I	Route Number, City	or Town, State, 2	Zip Code) 21649		
	Patricia L. Le	eager (daugh	ter) 1620 Pe	ters Corn	er Rd.	Maryde]	L, MD.		
	20a. Method of Disposition 1 Burial 2 Toremation 3 4 Donation 5 Other (Species)	Inemoval hom State K	Place of Disposition (Name of cemetery, crematory or other placent Cremation	ce) 4/28/		Location - City or	,		
	21. Signature of Funeral Service Las	M005	22. Name and Addre Galena F 510 118 West	ess of Facility Tuneral Ho Cross St	ome of S	Stephen	L Schaec 21635		
cal Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or contition resulting in death) Sequentially list conditions, it in the contition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 mortis? 1 1 1 2 Fetal death 3 Ectopic pregnancy 23d. Date of death 1 1 1 2 1 2 2 2 2 2								
Sompletec		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?						
3e (25. Was case referred to medical examiner?								
P	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Oth	ner: 4 Nursing Home	5 Residence	6 □Other (Spe	cify)		
rtification:	227. Mathre of Death 28d. Date of Injury 28d. Injury 1 Sec. Injury at Work? 2 Accident investigation M 1 Yes 2 No						injury occurred et and Number or Rural Route Number, State)		
Medical Ce	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example) Medical Example 29b. Signature and title of certifier	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred at the ti ation and/or investigation, in my	opinion, death occurred	at the time, date a	nd place, and due	e to the cause(s)		
	Jan K	dent	D5	8824	29d. L	Hate signed (Mont	n, Day, Year)		
	30. Name and address of person who Paul Donaher,			a					
0	31. Date filed (Month, Day, Year)	M.D. 119 C	. North Main	St. Galer	na, MD.	21635			
ar	MAY 1 2008	Barando Me	South						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 2008 8:05 Thomas Nolan Everett April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Denton 8551 Duffer's. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 DTM 2 □ F 138-36-1948 Director 63 February 1, 1945 New Jersey Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show odical Examiner must be notified at 1 ☐ Yes 2√2 No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8551 Duffer's Dell 21629 United States of America death v 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any Injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 ☐ Widowed 4 ☑ Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maintenance HS-Grad Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harriet Hanschka Pierson Everett Ruth ္ပ Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Dwyer 8551 Duffer's Dell, Denton, Maryland Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Locust Hill Cemetery: 4/26/08 Dover, New Jersey 22. Name and Address of Facility
Moore Funeral Home, P.A. 21. Signature of Funeral Service Liceuse 140 10 ML South Second Street, Denton, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4rs. 8mos disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25 Be Certification; To 27

Division or Vital Records, P.O. Box 68760,

				1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 ☐ Unknown			
				24a. Was an autopsy performed? 1 Yes 2 1 1 No	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	28b. Time of Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
3 Suicide 6 Could not b 4 Homicide determined		me, farm, street, factory,	office	28f. Location (Street and Nun City or Town, State)	nber or Rural Route Number,			
29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my know mIner: On the basis of examinat and manner stated.	wledge, death occurred at ion and/or investigation, i	the time, date and place n my opinion, death occ	e, and due to the cause(s) and r urred at the time, date and place	manner as stated. e, and due to the cause(s)			
29b. Signature and title of certifier	0.	29c.	icense number	29d. Date sig	ned (Month, Day, Year)			
> Shed	mm		D39887	4	21/08			
30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)						

State Registrar

Medical

David Smith,

29466 Pintail Drive, Easton, Maryland

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No

College (1-4or 5+)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates:

716 Elm Street

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 ☐ Widowed 4 X Divorced

Elementary/Secondary (0-12)

11. Marital Status

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mantal Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show Examiner must be notified at Baltimore, Maryland 21215-0036 Medical the permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

Funeral

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Physician /Medical Examiner

The law requires that the death certificate be executed and attending physician for use as the buria signed by the a certificate has birector, page 2 s To the Hospital or Attending Physician:

2

Medical

State Registrar

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

Completed Cashier Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Wesley Powell Mary Jane (Spiker) Powell Rae ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dick Elliott son 716 Elm Street Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Maurial 2 □ Cremation 3 □ Removal from State Restlawn Memorial Gardens 4/29/2008 4 ☐ Donation → ☐ Other (Specify) LaVale MD 21. Signature of F neral Service Loc 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, check, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) piratio Week Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4□Pregnant at time of death Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 27. Manner of Death Certification: 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number

21502

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

(Give kind of work done during most of working life. DO NOT use retired)

1 □ Yes 2 □ Xo

16a. Decedent's Usual Occupation

Reg. No.

Year

2008

ALLEGANY

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

14. Race - American Indian,

white

Black, White, etc.

3. Time of Death

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

5:35 A^M

DHMH 17 Rev 1/2001

24 hours a

within 2 To the

D0025406

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

900 seton

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

bonald manger Year) 2008

Brive, Cumberland, mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 13^y, Beatrice 2008 Feinstein 3:20 A. M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens Columbia Howard 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In vrs. last hirthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 □ M 2 □ F Months Days Hours 82^{Yrs} Director 204-20-1284 1925 Pennsylvania Usual Residence of Decedent the Maryland r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Columbia TY☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 7110 Minstrel Way, # 127 21045 U. S. A. Pages 1 and 2 should be filled within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: ģ 3 Widowed 4 □ Divorced Specify: White Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 1/2 Years Elementary/Secondary (0-12) Administrative Assistant Elementary Schools and Mental Hygi is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Usset <u>Mollie Gross</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Alyse Borakove - Daughter 5902 Perfect Calm Court, Clarksville, Maryland 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Judean Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 4/17/2008 Olney, Maryland 21. Signature of Funeral Service Licenses Edward Sagel Funeral Direction, Inc. Donald (1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the trath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Dementia 15 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Day Year 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an has page autopsy certificate performed? 1☐ Yes 2 ₩ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 28b. Time of 28d. Describe how injury occurred or Attending 1 XNatural 5 ☐ Pending investigation after death. 2 Accident 1 ☐ Yes 2 ☐ No the 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital within 24 hours a To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

Harry Li, M. D. 8600 Snowden River Parkway, Suite 301, Columbia, Maryland 31. Date filed (Month, Day, Year) APR

1

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

D56531

April 14, 2008

21045

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month April Physici<u>an</u> 2008 10:00 PM 16 Susanna C. Fowble /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Ellicott City 2809 Deer Trail Court 8. Date of Birth (Month, Day, Feb 23, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number 6 Sex **Funeral** Months 1 □ M 2 1 X 1913 Pennsylvania 189 05 2130 95 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Exercity or other traumatic event, the Medical Exercity. 10d. Inside City Limits 10c City Town or Location 10a. State 1 ☐Yes 2 No Director MD Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 United States 2809 Deer Trail Court Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susanna Mehalko Steven Cigarski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7430 Randolph Court Hanover, MD 21076 Patricia T. McLellan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4-22-2008 Owings Mills, MD Garrison Forest Vet. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner anc if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 DEctopic pregnancy Month Day Year 5 Other (specify) I ☐Yes 2 🗷 No the 9 Unknown signed by death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**K** No 2 No 1∏ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospire. — within 24 hours after death.

To the Funeral Director: After this c 1 Yes 2N No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Iniury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🟋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 18, 2008 3+9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elo

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State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2008 2:03 a.m. April 8, Daryl Eugene Hahn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Social Security Number **Funeral** Months 1★ M 2 F 445-28-7686 March 17, 1930 Oklahoma 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County i Hygiene. other than "natural", or items 23a or 2007 vent, the Medical Examiner must be notified at Maryland MOntgomery Gaithersburg 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **#9** Chestnut Street 20877 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?1 ★Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify. þ 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hahn, Dary Elementary/Secondary (0-12) College (1-4or 5+) Barber Hair cutting 1 and 2 should be filed w Health and Mental Hygie om 27 is marked other ti Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Haze1 Samuel Arthur Hahn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau 20871 12105 Piedmont Road, Clarksburg, Maryland Juanita Compton - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-16-2008 Stauffer Crematory Frederick, Maryland 4 Donation 5 Dother (Specify) 21. Sign sture of Funeral Service Ligensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE LIVER DISTASE /Medical Due to (or as a consequence of): Examiner LIVER CIRRHOSIS ALCONOLIC Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. ed by the a 9□Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ PNEUMUNIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has lirector, page 2 s 1□ Yes 2 🗹 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No မှ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral |
completely filled 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HULLING D0062562 Machon APRIL OR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+1 CENTER DRIVE ROCKUILLE MAKYLAND 20850 9901 MEDICAL MADHAVI HUBBLY 31. Date filed (Month, Day, Year) 32. Registras Signature State 2008▶ APR 1 Registrar

Funeral Director Baltimore, Maryland 21215-0036

^{Day}2008 April 15, **Physician** Beth Hunt 6:30 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Buckingham Choice Adamstown Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 ▼ □ F 311-03-0534 88 Oct 18, 1919 Indiana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Mexical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 ☑ No Maryland Frederick 5698 Crabapple Drive Frederick 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5698 Crabapple Drive 21703 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No USA Completed by Specify: 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Riley Brooks Maye Elizabeth Shake ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hollice Looney - daughter 5223 Fairfreene Way, Ijamsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Stauffer Crematory 4-16-2008 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signalyre of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland Olline 21702 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding p IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Anemia 1 Tes 2 No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 🐼 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🗹 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-15-2008 00058726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3000-D Ventrie Ct. Myersville, mo 21773 MO Warren 31. Date filed (Month, Day, Year) State APR 1 7 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle Last) Day Year **Physician** Howard Francis Joiner 2008 <u>Apri</u>l /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner Caroline Nursing Home, Inc. Denton Caroline If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Days Months Hours 1 □XM 2 □ F 89 Director 213-03-9023 June 16, 1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland la or 28a-f show t be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a dical Examiner must b 11599 Kibler Road 21639 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No þ Specify: Caucasian 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 HS Grad Shop Foreman Home Construction Department of Health and Mental Hygi Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental William Robert Joiner Florence Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maxine LaRue Joiner Wife 11599 Kibler Road, Greensboro, Maryland or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 5 Other (Specify) Denton Cemetery 4/27/2008 Denton, Maryland 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 21. Signature of Funeral Service License 23a. Part1. Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical SB attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy performe certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No ပို 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division or Vital Records, P.O. Box 68760,

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

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cause of death Tem 23a) (Type, Prin

's Signature

32. Registra

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **JOHNSON** PAULINE Ε. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HICOMION SALIBUN 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 15, Age (In yrs. last b Social Security Number Maryland 214-03-5799 1 □ M 2 🖫 F 91 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Crisfield Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 U.S.A. 26647 Old State Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Assembly Cutlery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle M. Somers John Edward Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Hudson Street - Crisfield, MD Gayle Ward (Friend & PR)

permit. Page Department c Important: If any Injury or once,

Physician

/Medical

Examiner

10a. State

Director

Completed by Funeral

Be

Funeral

Director

and 2 should be filed within 72 hours after death with the Maryland

Pages 1

Baltimore, Maryland 21215-0036

it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

> burial-transit as use page s after death.
>
> I Director: A id in by the fu

Division or Vital Records,

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	20a. Method of Disposition	20b. Place of Disposition (N cemetery, crematory o		Date 20c.	Location - City or To	wn, State
	1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Sunnyridge Memo		'22/08 c	risfied, D	MD
	21. Signature H. Bradshaw, Jr.	Brad	and Address of Facility shaw & Sons I W. Main St.			17
	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	us dusal				Approximate Interval Between Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):				
Medica	IF FEMALE:			_		
ysician/l	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown		23d. Date of deliver Month	ery Day Year		
d by Ph	Part II. Other significant conditions contributing to death	23e. Did tobacc	co use contribute to t			
complete	CAQ Amial Fibrillation	η,		24a. Was an - autopsy performed 1 Yes	prior to co	opsy findings available impletion of cause of
Be	25. Was case referred to medical examiner?		Othor:	eath (Check only one)		
Medical Certification: To	27. Manner of Death 1. Matural 5 Pending (Month, D) 2 Accident investigation	ury 28b. Time of	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in		<u>(y)</u>
Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of ir building, €	njury - At home, farm, street, fact etc. (Specify)	tory, office	28f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
edical (29a. Certifier (Check only one) Continue Continue					
Me	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
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State Registrar

R.

31. Date filed (Month, Day, Year)

within 24 hours aff

To the Funeral D

completely filled in

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Drive, SALISRURY M.D. 2187

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 18, 2008 ANNABELL **JOYNER** April 9:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23 Columbia Avenue Crisfield Somerset 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🗙 F 220-26-3824 77 Director March 14, 1931 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 28a-f show Maryland Somerset 1 ☐Yes 2 ☐ No Crisfield Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Columbia Avenue 21817 II.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or lie any Injury or other traumatic event, the Medical Examine. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ Specify: 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eddie Townsend Lillian Collins ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melton Joyner, Jr. (Son) 23 Columbia Avenue - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 4/22/08 4 Donation 5 Dother (Specify) Crisfield, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature Robert H. Bradshav ŹΓ. 306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final META STATIC Physician LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical ass 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **X**No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e 48098 April 18, 2008

DHMH 17 Rev 1/2001

State Registrar

677

- 201 Hall Highway - Crisfield, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

M.D.

32. Reistrar's Signature

Vijay Karumbunathan,

APR 21

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Ernest Hugh Kelly April 13 2008 11:30a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Rockville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Director 579-50-4480 68 18,1939 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 2 should be filed within 72 hours after death with the Marylan n and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Director Montgomery Maryland Derwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16905 Glen Oak Run 20855 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter HVAC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Vernie Lee Dent Ernest Lewis Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is n any Injury or other traur Dixie Lee Kelly / Wife 16905 Glen Oak Run, Derwood, <u>Maryland 20855</u> Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/2008 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown 21. Signature of Fureral Service Lice fer Funeral Homes Opossumtown Pike, P. A. Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sensis /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA ၉ 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Matural 5 Pending investigation M 1 ☐ Yes 2 ☐ No nours after death. Ineral Director: / y filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day

Ardekani Sanaei MD 9901

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

s Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Medical Center Drive, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 17, 2008 **Physician** 8:42 AM April Smith Knight Shirley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Kensington 4917 Aurora Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Aug 16, 1 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday, 6. Sex 5. Social Security Number Funeral 1 □ M 2 T F 211-24-7808 75 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County r 28a-f show notified at 10a. State 1 ☐ Yes 2X No Director Kensington MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number d 2 should be filed within 72 hours after death with th and Mental Hygiene. ?7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a USA 20895 4917 Aurora Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black. White, etc 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 <u>م</u> 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Non-profit Organization Data Entry Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Seely Charles Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a:
Important: If Item 27 Is
any injury or other trau 4917 Aurora Drive Kensington, MD 20895 Robert S. Sanders/son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 104/18/08 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical as the l IF FEMALE: use yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth Month Year Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a I□Yes 2XINo 9□Unknown 9 Unknown rate nas been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 XNo 1∐ Yes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3□ DOA 2 Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title scentifier April 17, 2008

6 G.

State Registrar

Jan Bachowski, 31. Date filed (Month) PR 32. Registrar's Signature 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 11125 Rockville Pike #104 Rockville, MD 20852

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			1 - State Registrar			tificate of L		Reg.		1100
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	/Medic Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, or	Location of Death		4c. County of Death	
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	Funeral Director		517-54-2539	M XXE	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye May 16,	9. Birth Cou 1948 Mont	place (State or Foreign ntry) Cana
	ter death with the Maryland Items 23a or 28a-f ehow	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 X No
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p		Be (17. Father's Name (First, Middle, Last)				18. Mother's Name (,	
Maryland		^L	Karl Roy Ste	rner	19h Mailir	on Address (Street	Vera Ma and Number or Rural R			ip Code)
Ma	d 2 state		Kevin R. Kefauver	- CH			ove, Columb			,
	is 1 and Heal		20a. Method of Disposition		20b. Place of Dispo		Dat		c. Location - City or	own, State
Ë	Page nent c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	R.A. Ferr		4/28/0	08 W	est Cheste	er, PA
Baltimore,	permit. Page Department Important: eny injury once.		21. Signature of Funeral Service Litense	MAKE	862bre	2. Name and Address	ss of Facility Tari	cing-Car	go Funera. 3399	LHome, P.A.
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
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68	ntifica ng ph as th	Medi	IF FEMALE:			-				
P.O. Box	that the deeth certificate be led by the attending physicial detached for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	<i>'</i>		23d. Date of deli Month	very Day Year
Records, P	Physician: The law requires that the this certificate has been signed by the trial director, page 2 should be deteched.	þ	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		cco use contribute to	. /
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Division	Attending ir death. ector: After by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, st	reet, factory, office	28	Bf. Location (Stre	et and Number or Ru	ral Route Number,
Ö	tal or	Certification:	4 Nothicide	building, etc.	(эрөспу)			Only or rount,		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical			examination and/or in		me, date and place, ar opinion, death occurred			
	To th withir To th	ž	29b. Signature and title of certifier	Al I	\	29c. Licens	se number	290	d. Date signed (Monta	n, Day, Year)
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	Sta Regist		31. Date filed (Month, Day; Year)	Registra	r's Signature	All I		•		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** D. Charlotte Lee APril 14 2008 2:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8558 Fingerboard Road Frederick Frederick 8. Date of Birth (Month, Day, Year) MAY 28, 1917 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 F Days Hours Months Min. **Director** 579-01-7507 90 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show must be notified at 1 Yes 2 No Director Frederick Maryland Frederick 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 21704 United States 8558 Fingerboard Road 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. traumatic event, the M. dical Examiner 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White Be Completed by Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) County School Board Cafeteria Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Ralph Charlotte D. Remsberg Fritz ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
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once. 8558 Fingerboard Rd./ Frederick, Maryland 21704 Stephen R. Lee / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/17/2008 Frederick, Maryland 4 Donation 5 Dother (Specify) Mount Olivet Cem. 21. Signatur o Funeral Service Licensed 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/ Frederick, MD 23a. Pakt Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4 des disease or condition resulting in death) en when Due to for as a consequence of) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 signed by the attending physician Certification: To Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? detached for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2/2/10 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the f within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month. Day.

Year.

APR 16

. Registra

DHMH 17 Rev 1/2001

Registrar

2008

08-03047 Richard Lomax

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day April 19, 2008 1220 hrs Richard E. Lomax Jr Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death N/A **Baltimore** Harbor Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Foreign coMia;)ry1and Min. Months Days Hours 1972 Mar 31 Director 219-88-4450 36 Yrs 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Baltimore Baltimore 1 Yes 2 XNo Maryland 23a or 28a-f show Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21226 1620 Popland St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No Specify: Black Yes 2 X No specify: f Yes, Give Year Widowed Divorced Š 6b. Kind of Business/Industry Annapolis 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Service Center Tow Truck Driver 21215-0036 O 11th it: If item 27 is marked other other traumatic event, the Me 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked oth injury or other traumatic event, the Margie Chapman Richard E. Lomax Sr 8 Teld Gefing Andress n (Singertern Niffshrepp Roman Romadhumbe Activor Tolon) State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, Md. 21060 Baltimore, MD Margie Lomax (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4-25-08 Annapolis, Md. Memorial Gardens 4 Donation 5 Other Specify: 2W Harne and Andressen F&ilitySons Mortuary, 21. Signature of Funeral Service Licensee 21401 821 West St. Annapolis, Md. , Teese Approximate Interval 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Retween Onset and failure. List only one cause on each line. Death /Medical Narcotic and alcohol intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical X UNPENDED X AM#1,53a,27,28a-f, perME,g879 5/14/08 TT After this certificate has been signed by the attending physician uneral director, page 2 should be detached for use as the burial Records, P.O. Box 68760, The law requires that the death certificate be 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown δ Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 2 No ✓ Yes 26.Place of Death (Check only one) : Hospital or Attending Physician: 24 hours after death.
E Funeral Director: After this certificately filled in by the funeral director, 1 25. Was case referred to medical Division of Vital Be Other, Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: Natural 1 Yes 2 Y No 5 Pending Fnd 4/19/2008 FNd unk pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 1620 Popland St. Curtis Bay, MD Suicide Found: residence determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 20, 2008 O.C.M.E. n 1) 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD egistrar's Signatu

State Registra

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Mike Milanzi 2008 10:50 PM April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Montgomery Hospice Casey House Montgomery Rockville 6. Sex if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 20, 1954 Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1X M 2 □ F 54 215-51-6415 Malawi Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Germantown 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 11627 Summer Oak Drive 20874 Malawi Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify 2 Specify: Black. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Banking 4 d 2 should be filed what and Mental Hygiel ? Is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit, Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Jafali Milanzi Fricana Gondwe 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie A. Milanzi / Wife 11627 Summer Oak Drive, Germantown, Maryland 20874 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition unk Date 20c. Location - City or Town, State Pages nent of h 1 Burial 2 □ Cremation 3 □ Removal from State Family Cemetery 4 □ Donation 5 □ Other (Specify) Karonga, Malawi 21. Signature of Fungral Service Licensee .22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Acute Cholecystitus Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-trar and Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signage 2 should b Human Immunodeficiency Virus 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2K No certificate has 1☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ MOther (Specify) Hospice 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 X Naturai 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No Hospital or Attenditions after death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital

State Registrar

To the within 2

Box 68760

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Records.

Division or Vital

31. Date filed (Month, Day, Year)

29b. Signature and title of cortifier

29a. Certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

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29d. Date signed (Month, Day, Year)

April 14, 2008

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29a. Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		the Ho nin 24 the Fu	ledic	one)	and ma		Illiation and/or			, carron at the time						
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		To To To	2	29b. Signature and title of certif	07 51	W	ME) DO	6243	2	L///	4./1	S roar)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		3		30. Name and address of pare	on who completed or	ause of death	(Item 23a) (Type	e, Print)	2) J	-1/1	1100				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 14, 2008 12:05 p M Richard McCarthy Maurice /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery 9004 Kimes Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min. 1 → M 2 □ F 31, Iowa 484-09-6291 87 Dec. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County show at 1 ☐ Yes 2 X No ral", or items 23a or 28a-f sh Examiner must be notified Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number with USA 9004 Kimes Street 20901 permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ∑Yes 2 □ No If Yes, Give WWII era Year or Dates: 1 Never Married XX Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chief o of Vietnamese & Thai Voice of America 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carell Cox McCarthy Mary Clare Gribbon ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9004 Kimes Street, Silver Spring, MD 20901 Helene Sze McCarthy/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Buriat 2 Cremation 3 ☐ Removal from State ${\tt April}^{\tt Date}$ 17. Metropolitan Crematory 2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: use If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the and be detached for Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Peripheral Vascular Disease, Congestive Cardiomyopathy, Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has Atrial Fibrillation perform certificate 2 X No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 □ Nursing Home 5 🗷 Residence 6 □ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Year) Injury 1 X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD April 15, 2008 D55522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert H. Gerard, MD 1500 Forest Glen Road, Silver Spring, MD 20910 32 Registrar's Signature 31. Date filed (Month, Day, Year) State **APR 17** 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Month **Physician** 11:59 PM Billie Jo McFee April 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year Months Days Hours 1 □ M 2 🕶 F 400-44-2981 Kentucky Aug. 17,1936 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Anne Arundel MD Pasadena 1 ☐ Yes 2 XNo Director with the I 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21122 8240 Shady Nook Court death v Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene.
em 27 is marked other than "natural", or ite wher traumatic event, Ite Medical Examina 1 ☐Yes 2 X No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: <u>ک</u> White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker **Home** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Prentice Rosco Gibbons Lydia Brummett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 776 Oak Grove Circle Severna Park, MD 21146 Leslie Overholser/ daughter permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troone. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 21, 1 XBurial 2 ☐ Cremation 3 X Removal from State Louisville, Kentucky Cave Hill Cemetery 4 Donation 5 Dother (Specify) 2008 Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Tuneral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Ischemic Bowels Sequentially list conditions, if any, leading to immediate cause. Enter thin derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Lung Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No Hypertension 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/12/08 D0041284 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymundo Caparros 1600 S. Crain Highway Glen Burnie, Maryland 21061 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State More & good APR 1 6 2008

DHMH 17 Rev 1/2001

Registrar

			State Registrar		Cei	rtificate of l	Death		Reg. No.	UUU	1	1343
			Decedent's Name (First, Middle, La.	st)				2. Date of De			3. Tim	e of Death
	Physicia		HAROLD S.	MILLER, JR.				Month APRIL	Day 25	2008	3 4	:55a [™]
	/Medic		4a. Facility Name (If not institution, give			4b. City. Town, or	Location of Death	***********		ounty of Death		• 33a
	Examin	er	Chester River			Cheste			K	ent		
	46.00		5. Social Security Number 6. S		ast birthday)		If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (Sta	ate or Foreign
	Funeral Director			2 2 M 2 □ F 65	Yrs.	Months Days	Hours Min.	(Month, De Dec 2	y, Year) 5 19	Cou	intry) itucl	
ь	Director	1	Usual Residence of Decedent			<u> </u>		200 2	5 .5	12 1(01		-1
	and w		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Insid	e City Limits
	sho	5	MD Oueen	Annole Ch	ester	tour					1 🔲	Yes 2 No
	the N	ect	10e. Street and Number	Airie 5 Cii	escer	10f, Zip Code			10a. Citize	en of What Cou	intry?	
	with a or a	Funeral Director	1100 Round To	n Pd		21620			U.S		, .	
	s 23	ral		12. Was Decedent Ever in U.	0 40		ionania Origin? (Sp	onify Vac or No		. Race - Amer	ican India	1
	er de Item	Š	11. Marital Status	Armed Forces?	0. 10.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White		-,
20	or amil	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🔼 No	Specify:		8	Specify: W	hite	
2-0030	be filed within 72 hours after death with the Maryland ital Hyglene. ad other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's Ed		16a Dece	dent's Usual Occup	ation		16b. Kind	d of Business/I	ndustry	
Ö	"na"	Completed	(Specify only highest gra	ade completed)	(Give	e kind of work done of DO NOT use retired	during most of work	ing	ī.	merica	•	
Z	withill she.	Ë	Elementary/Secondary (0-12)	College (1-4or 5+)		uck Driv			l	d Cons		ction
Z	led y	ပိ	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle			JCIU	001011
yland	he f	B	Harold S. Mill				Ruth P			-		
Ĕ	2 should be and Mental Is marked or raumatic ev	은			40h Maili	na Address (Street					in Cada)	
Z Z	2 st and r		19a. Informant's Name/Relationship (Ellen Miller	(wife)		Round					, ,	1620
45	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	(8:		•				Date		ation - City or T		
5	Pages 1 a nent of Hee int: If item iry or othe		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	osition (Name of matory or other place	ce) 4/2					6
Ē	Pag men ant: ury		4 Donation 5 Dother (Special	37	umpte	on Cemet	ery 4/2	9/08	Crum	pton,	MD.	
galti	permit. Pages Department of Important: If it any Injury or o once.		21. Signature of Funcial Service Lice	1969	2	2. Name and Addre	ss of Facility	ome of	Sto	nhen I		chaoch
ם	8 2 E 2 9		1100	M005		lena Fu 18 West				MD.	2163	5
			23a. Part1 Enter the disease, or com shock, or heart failure. List only	plications that caused the death	n. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approx Interva	imate I Between
	Physician		Immediate Cause (Final disease or contion		A \	Aug (~ 11. 1.	40°C		-	Onset	and Death
	/Medical		resulting in doth)	a. Due to (or as a consequ	uence of):	in syn	e (mi)	113				1293
	Examiner	Н		Same	bre	in Sun	dome				6	mo-
		ē	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to low a consequ	uence of):	1					_	- • •
	uted	효	Cause (Disease or injury that initiated events	Remove	ta	UTI					1	wrs.
'n	exec n and ial-tra	Examiner	resulting in death) Last	Due to (or as a consequence	uence of):							
09/89	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit			_d.								
Q	ficate g phy is the	Medical										
×	certi		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna					23	3d. Date of deli	very	
9	atter for u	cial	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		□Ectopic pregnanc: □ Other <i>(specify)</i> _	y 			Month	Day	Year
j.	the d	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
7	law requires that the as been signed by th 2 should be detache	된	Part II. Other significant conditions	contributing to death but not res	ulting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to	the cause	of death?
ecords,	sign sign d be	l by	Mypertension					1 🗆	Yes 2	No 3 □ Pro	obably 4	4 Unknown
Ö	requ	etec	Triffer Total					04- 18/		041- 11/1		la an annaile la la
ê	288	Completed						24a. Was		24b. Were au prior to death?	ompletion	of cause of
Vital K	The page	Ö						1□ Yes	2 No	1 ☐ Yes	2 No	
=======================================	ysician: is certific director,	Be	25. Was case referred to medical examiner?			l au	26. Place of Dea					
5	Je Pis	၉	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing H	ome 5□Res	idence 6	□Other (Spec	cify)	
	iding Phys th. After this funeral dir		27. Manner of Death ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	ry at rk?	28d. Describe	how injury	occurred		
<u>Ö</u>	ath. or: A	atic	2 ☐ Accident investigatio			M 1 🗆	Yes 2 □ No					
DIVISION	ar de recte by ti	li li	3 Suicide 6 Could not be determined		ome, farm, st	treet, factory, office		28f. Location City or To	(Street and wn, State)	Number or Ru	ral Route	Number,
5	safte al Di	Certification:										
	ospit hour uner ly fills			hysician: To the best of my kno miner: On the basis of examina								(s)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Medical	one)	and manner stated.			opanion, death occu	ou at the tille	, dute and	p.acc, and ude		
	To the To the To the Complex C	ž	29b. Signature and title of certifier			29c. Licens	_			signed (Month		ar)
				CM ~		7)	51733			+)286	08	
			30. Name and address of person who	completed cause of death (Iter	n 23a) (Type	, Print)						
			Frederick Delb			nurch Hi	11 Rd	Cheste	rtow	n. MD	21	620
		ate	31. Date filed (Month, Day, Year)	2. Registrar's Signa			!/ !	<u> </u>	W			V = V

DHMH 17 Rev 1/2001

State

Registrar

MAY

1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2:25 PM 2008 Knight Mann April 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Heritage 7 Low Ford Ma donna arrelfsuil4 If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9/9/1921 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Maryland 86 Director 214-22-2110 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Jarrettsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21084 USA 3982 Norrisville Road by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Men College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George M. Knight Mary Morris ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tom Galbreath/Son 2204 Eric Court, Evansville, IN 47720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Street, Maryland Dublin U.M. Cemetery 4/18/08 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Part1. Inter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death yain Immediate Cause (Final Physician Demenha disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1☐ Yes 2☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Myothyrord 24a. Was an autopsy performed? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) | Notation | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Specific | Nursing Home | Nursing Home | Specific | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home | Nursing Home Hospital: 1 | Yes 2 | → No ၉ 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31295 4/15/08 MO

State Registrar 31. Date filed Month, Day, Year)
MAY 0 1 2008

Klopsz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

Charles St

ORIGINAL

21204

7. win

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Day Physician Farkhanda Nazli 2008 15 April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 30/1364/4 HICONICO TENINSULA REGIONAL If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex ge (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F 62 214-73-1333 Pakistan 1946 Director Jan. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County tx∑xYes 2 No MD Wicomico Salisbury Directo 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21804 1104 Planters Place Pakistan Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 21 No f Yes, Give rear or Dates: 1 ☐ Never Married 2 🔀 Married Asian 1 ☐ Yes XOXNo Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Muhammed Omer Khan Bibi Jan P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1104 Planters Place, Salisbury, MD 21804 Nasir Awan/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mohammed Bukas Cem. 04/16/08 Federalsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) YEAR Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director name? Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year in the past 12 months? 1☐Yes 2☐No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∏ Yes 2 40 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 1 7 2008

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Registrar's Signature

Gretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		I- For State Certin	ficate of	Death		Re	g. No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)				2. Date of Death Month	Day Year	3. Time of Death 1855 hrs
ledical Exami		Richard Keith Penn 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	cation of Dea	April 25, 20	4c. County of De	
		Easton Memorial Hospital		Easton	ocation of Dec	2011	Talbot	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24H	Irs. 8. Date of Birt	h(MM/DD/YYYY) 9.	Birthplace (State or
Director		217-74-9458 1XM 2 F 44	Yrs	Months Days	Hours M	February	8, 1964	eign Countr M ary1and
	-	Usual Residence of Decedent						10d. Inside City Limits
w any			own or Locati	1011				1 Yes 2 No
Aaryland 28a-f show	횽	Maryland Caroline De	enton	10f. Zip Code		10	g. Citizen of What C	
- L 0	Director			21629				tes of Americ
ath with the tems 23a or st be notified		25265 Smith Landing Road 11. Marital Status 12. Was Decedent Ever in U.S.		s Decedent of Hispa		Specify Yes or No-	14. Race - An	nerican Indian, Black,
leath v	Funeral	1 Never Married 2 X Married Armed Forces?	If Y	es, specify Cuban, I	Mexican, Pue	erto Rican, etc.)		American ndian
	by F	Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No			Specify: -	aucasian
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21215-0036 / wide be filed within 72 hours a Mental Byggiene. marked other than "natura c event, the M. iteal Examin	Be (Terrence O'Neil Pennell			Augu	sta Mari	e Wilt	
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MD and 2 sho salth and 2 sho em 27 is	- 1	Lynda J. Pennell Wife 20a. Method of Disposition 20b. Pla		5 Smith La sition (Name of ceme		Road, De	nton Mar 20c. Location - City	v 1and 21629 or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State	ematory or ot	ther place)	- 1	/26/2009	Davan	01011010
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Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic es		Randolph Move	M _C	oore Fune:	ral Ho	me, P.A. Street L	enton. Ma	ryland 21629
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	2 Accident Investigation 28e. Place of Injury - At hor	me, farm, stre	eet, factory, office bu	uilding, etc.	28f. Location (or Town,		or Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Bire		4 Homicide determined (Specify) 29a. Certifier A Continue Physician To the boot of my knowledge			to and place	and due to the new	no(n) and mappes on	stated
To the Ho within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination an	a, death occu d/or investiga	urred at the time, dai ation, in my opinion,	death occurr	ed at the time, date	and place, and due	to the cause(s)
To with	Mec	and manner stated. 29b. Signature and title of certifier		29c. License		-		(Month, Day, Year)
		(and Hellan		O.C.N	И.E.		April 26, 200	3
		30. Name and address of person who completed cause of death (Item:		Chart D W	are MD C	1201		
		Loo Builded Circles		Street, Baltimo	ore, IVID 2°	1201		
S Regis	tate trar		Los	while				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Johnathan William Paroaco

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		4a. Facility Name (if not institution	on, give street and n	umber)		4t	o. City, To	wn, or Lo	cation of	Death		4c. Co	unty of Dea	ath	
		Sandy Point State Pa	ırk				Sandy	Point				Ann	e Arunde	el	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthda	y)	If Under		If Under		B. Date of Bi	rth(MM/DD/	YYYY) 9. E	Birthplace	e (State or
Director		214-80-8432	1 M 2 F	33		Yrs.	Months	Days	Hours	Min.	10/2	7/1974	+ (Country)	aryland
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daryland 28a-f show	흱	10e, Street and Number	Arunder		ICTV	1	10f. Zip (Code	-		1	10g. Citizen	of What Co	l ountry?	
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	다 B	19a. Informant's Name/Relation			19b. M	Mailing	Address	(Street	1000			mber, City o			
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	Check only Certifying	Physician: To the b aminer: On the basi	est of my knowl s of examination	eage, death n and/or inv	occuri estigat	ied at the ion, in my	opinion,	death oc	curred at t	ue to the ca the time, da	te and place	, and due t	to the cau	use(s)
To the within To the complet	Ned	29b. Signature and title of certification	and manner	stated.					number				te signed		
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1,400		30. Name and address of person Pameta E. Southall,		use of death (It t Medical E:		11	1 Penn	Street	Raltim	ore Mr	D 21201				
140				Registrar's Sign		11	. i eiiii	- u eel,	, vaiuiii	J. C., IVIL	1201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Edward Laforce Pridgen April 16 2008 12:10a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**X** M 2□ F Yrs. Sept. 10.1921 Director 86 Georgia 257-18-3073 10d. Inside City Limits 10a. State 10h Counts 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23s or 28s-f show other treumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No MD Dorchester Director Cambridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1205 Hambrook Blvd. 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 and 2 should be filed within 72 hours after whealth and Mental Hygiene. Bm 27 is marked other than "natural", or Itel 1XYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white If Yes, Give Year or Dates: à WWII 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) construction plumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) John F. Pridgen Mae Oakes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a Betty Lou Pridgen wife 1205 Hambrook Blvd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 tment of F 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 4/19/08 Cambridge, MD 21. Signature Huneral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician aspiration

Due to (or as a consequence of): Week Preumonia disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): monte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed Cerebral Vas Cular accident ed by the attending physicien and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Pe 201tic 5 tenosis 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 1 Yes 2 10 No o the Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 ursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ 106 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 11-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier hosos HO059973

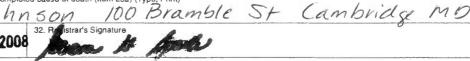
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State 31. D Registrar

atricia

31. Date filed (Month, Day, Year)
APR 1 8 2008

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 8:45 P 13, 2008 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital 01ney If Under 1 Year Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 K F 12, New York Director 081-22-0629 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location th and Mental Hygiene. ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1KTYes 2 □ No Director FL Broward Plantation 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 8545 North Campanelli Blvd. 33322 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Philip Krassner Esther Bondar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health 1012 Crest Park Dr. Silver Spring, MD 20903 Paul Rothberg - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ò 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4/15/2008 Mount Lebanon Adelphi, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licence Danzansky-Goldberg Memorial 1170 Rockville Pike Rockvi Chapels, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Workening **Physician** dou UMONIO /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physlcian: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnap 3 | Ectopic pregnancy Year Month Day in the past 12 months 1 ☐Yes 2 ☐Mo Division of Vital Records. P.O. certificate has been signed by the rector, page 2 should be detached to 9 Unknown 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 2 ☐ NO 1 ☐ Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 | N N Linbatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident inyestigation 6 ☐ Qould not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide etermined t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and itle of certifie ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 31. Date filed (Month, Day, Year)
APR 17 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 14350

		1- For State Registrar		Certi	ficate of	Death				_	Reg. N	lo.		
Physic		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Y										y Yea	ır	3. Time of Death 1945 hrs
െ " al Exam			noso-Rami							April 17,	2008	3	4.50	
		4a. Facility Name (if not institution	on, give street and nu	ımber)	4	b. City, Tow		cation of	Death			4c. County	of Death	1
		Chester River Hospita	al Center			Chester						Kent		
Funeral	_	5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1		If Under	24Hrs. Min.	8. Date of	Birth (M	M/DD/YYYY	9. Bir Foreig	thplace (State or
Director		N/A	1XM 2F	40	Yrs.	Months	Days	Hours	IVIII I.	Dec	15	1967	Co	ountry)Guatemala
	1	Usual Residence of Decedent												
any	1	10a. State 10b. County			own or Location	on								10d. Inside City Limits
nd show		Maryland Caro	line	Ma	arydel									1 Yes 2 X No
aryla 8a-f:	ᅜ	10e. Street and Number				10f. Zip Co	de				10g. (Citizen of W	hat Cou	ntry?
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death with the Maryland or items 23a or 28a-f show must be notified at once.	<u>a</u>	11. Marital Status	12. Was De	cedent Ever in U.S	. 13. Was	s Decedent	of Hispa	anic Origi	n? (Spe	cify Yes or	No-		e, etc.	rican Indian, Black,
leath ritem	Funeral	1 Never Married 2 X	Married Armed F	2 X No	III Y	es, specify C	aban, r	wexican,	rueno r	ican, etc.)		1		
fter d I", or		3 Widowed 4 Di	vorced If Yes, Give Ye			Yes 2				ema1a		Specify:		spanic
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	o o	15. Decedent's Education (Sp.		ide completed)	16a. Deceden	t's Usual Oc ost of workin					16	b. Kind of B	usiness.	/Industry
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Francisco Reyn			19b. Mailing	Address	(Stroot							te, Zip Code)
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Then 71 is marked other than "natural", or items 23a or 28a-5 sho reanmarie event, the Medical Examiner must be notified at once.	۱۵	19a. Informant's Name/Relation Carlos Reynos		/ brothor			•					ryland		
MD and 2 sho alth and 2 is raumati		20a. Method of Disposition	0-Kallittez		lace of Dispos				Hai	Date				or Town, State
TOFE, ages 1 a mt of He nt. If ite		1 X Burial 2 Crematic	on 3 Removal		ematory or other ales C		cio		5/2	000	,	212011	na	Guatemala
im Page	5	4 Donation 5 Other		uv				of Familia		008		aragu	na,	Guacemata
Baltimore, M permit. Pages 1 and 2 Department of Health Important. If item 2		21. Signature of Funeral Service	e Licensee	_ /	122.1	Name and Ade egle	and	He1:	fenþ	ein F	une	ral Ho yland	me,	PA
		23a. Part I. Enter the disease, of	or complications that	caused the death	Do not enter t	BOX I	dvina.s	Gree such as ca	ensb ardiac or	oro, respiratory	Mar arrest,	y Land_ , shock, or h	_∠ <u>1 0</u> eart	Approximate Interval
Physicia: Vedica		failure. List only one caus	e on each line.		20 1101 011101 1		-,,, -							Between Onset and Death
_xamine	-	Immediate Cause (Final diseas												
			condition resulting in death) Due to (or as a consequence of):											
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate	•	a consequence of):									
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760, cate be ex physician	ledical			s, outcome of pregr	ancy			-				23d. Date	of delive	ery
		IF FEMALE: 23b. Was decedent pregnant in				etal death	3	Ectopic	pregna	ncy		Month		Day Year
Sox 687 death certific	Physiciar	past 12 months?	j	gnant at time of dea	- 44	ther (Specif					- 1			()
Boy e deat	NS.	1 Yes 2 No 9 U		nown					-314		N' -1 4 - 1		Anily (for	to the cause of death?
P.O.			ditions contributing	to death but not re	esulting in the	underlying o	ause gi	iven in Pa	art I.					robably 4 Unknown
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/ita		examiner?	Hospital: 1	Inpatient 2	ER/Outpatien	nt 3 DC)A	Other ₄	Nursin	g Home 5	5 R	esidence 6	i Otl	her:
Sion of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certificate has been signed by the attending certor: After this certificate has been signed by the attending	ਛੂ ⊢ੋ	27 Manner of Death	28a. Da	ite of Injury	28b. Time of	Injury 28	3c. Injur	ry at Worl				w injury occ uto auto c		n n
onding ath.		1 Natural 5 Pe	anding .	nth, Day Year) 7, 2008	1810 hrs		1 Y	/es 2 √	No	rassen	Jei at	ilo auto c	JUIISIU	
Division tal or Attendit is after death.	מון מו	2 Accident In	vestigation 28e. Pl	ace of Injury - At ho	ome, farm, stre	eet, factory,	office b	uilding, e	tc.				nber or	Rural Route Number, City
Div rate or rate or	Certification	Suicide 6 Co		fy) Major Road	d / Highwa	У				18120 He	wn, Sta enders	on Road L	ot 6, M	larydel, MD
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	e S		Physician: To the i	est of my knowled	ge, death occu	urred at the	time, da	ate and pl	ace, and	due to the	cause	(s) and man	ner as s	tated.
thin 2	Medical	one) 2 Medical E	xaminer: On the bas	is of examination a	nd/or investiga	ation, in my	opinion	, death or	ccurred a	at the time,	date a	nd place, an	d due to	the cause(s)
F. E.	S S	29b. Signature and title of cert				29c.	Licens	e number						Month, Day, Year)
		(00.	0 1	a 1 01	a u		O.C.I	M.E.				April 18,	2008	
_		30. Name and address of pers	on who completed o	ause of death (Item	1 23a)									
			Assistant Medic		111 Penn	Street, E	Baltim	ore, MI	2120)1				
	Stat	31. Date filed (Month, Day, Yea	ar) 32.	Registrar's Signatu	ure A	Sall	9				-			
	istra		2 4 2008		6	7								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4-23-2008 10:42 P M Nora Louise Ridglev /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Catherines Nursing Home Frederick Emmitsburg If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yei 7-17-1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 📉 I 226-36-4911 80 MD Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23a or 28e-f ehow cilical Examiner riust be nutified at 1 ☐ Yes 2 No MD Frederick Frederick Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 8131 Cambridge Drive 21704 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in the of Health and Mental Hygiene. and I flem 27 is marked other than "natural, or its ury or other thaumatic event, the Muchical Expansion ury or other traumatic event, the Muchical Expansion. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence G. Mills ၉ Irene Briggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Ridglev Son 6590 Cole Brooks Lane Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If Ite eny Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem Grdn 4-28-2008 Frederick, MD 21. Signature of Funeral Service Vicenses 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church St. Frederick, MD 21701 M01176 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 301 eur: /Medical Dife to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran P.O. Box 68760, signed by the attending physician to detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should should 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate hes autopsy performed? Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only or Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: ဥ Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28b. Time of Injury 28c. Injury at Work? Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation t ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) ţ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 Soutal FrampEL-1400440 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EL-PORT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 MAY Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For Amend Items 23aPt1,11,25	per me, g882, 08	incate of E	eaith and iv Death		·g	14352
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	_	Harry Elmer Robey, Jr.			1 1 1 D 1	HPIII	4c. County of Dea	081 9.00 m
)	Examin	er	4a. Facility Name (If not institution, give street and numb		4b. City, Town, or I			Washingt	
			Washington County Hospita 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	Hagersto	If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
	Funeral Director		212-80-8684 Usual Residence of Decedent	78 Yrs.	Months Days	Hours Min.	(Month, Day, August 14,		(Country)
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Eximiliner must be notified at		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits 1 □ Yes 2 🕅 No
	e Ma Ba-f s	Directo	MD Frederick	Frederick				- C'' - / 14/1 - 1 C	
	or 28	Dire	10e. Street and Number		10f. Zip Code		10	ng. Citizen of What C	country?
	ath w		2090 Old Farm Drive Suite		21701			USA 14. Race - Am	erican Indian
	er de Items	Funeral	11. Marital Status 12. Was Decede Armed Force		Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
50	rs aft	by F	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	es:	1□Yes 2□xNo	Specify:		Specify: W	hite
3	thou stura	ed	15. Decedent's Education		dent's Usual Occupa			16b. Kind of Busines	s/Industry
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9500-91212	d with giene er tha	ĕ	6		abled			Disabilit	У
	al Hy d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Surname)	
Уa	should be nd Mental marked c	To Be	Harry Elmer Robey, Sr.			Pearl Wh		Oit - Town Chate	Zin Codol
Maryland	2 sh h and ls m		19a. Informant's Name/Relationship (Type. Print) Hazel Montgomery/Sister		ng Address (<i>Street a</i> Garfield <i>S</i>			; City or Town, State, DΔ 17201	, 21p Code)
	1 and Health em 27 ther to		20a. Method of Disposition		osition (Name of matory or other place			20c. Location - City of	or Town, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at ODGe.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St	ate cemetery, crei	matory or other place	e) 04/2	1/2000 1	Hancock M	ID.
	it. Partmentant		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	rian U4/4 s of Facility 1/11	Most Ma	Hancock, M ain Street	·		
g	permit. Departi Import any inj once.		The state of the s	1				ncock,MD 2	
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	ecute and trans	Examiner	that initiated events c	as a consequence of):	<i>€</i> (3 <i>G</i>)	J. C. C.	A MEDI	CALEXAMIII	
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68760,	ficate be executed physician and s the burial-transit	edical	d	4, 9, 7, 6, 7,	7.(010	CERTIFICATION			
Box (an/Me	23b. was decedent pregnant	ome pf pregnancy	⊒Ectopic pregnancy			23d. Date of o	delivery Day Year
P.O. B	faw requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ No		Other (specify)			Monar	Day Four
	that t ed by detac		Part II. Other significant conditions contributing to dea		underlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
gp	uires sign lid be	d by	Seizure Disorder, Hypothyro	idism			1 □ Y	es 2 ⊡ √No 3□	Probably 4 □Unknown
200	s beel	Completed					24a. Was a	ın 24b. Were	autopsy findings available
8	e – e	F					autops perfor 1∐ Yes	med? death	o completion of cause of ? es 2 □ No
ta	sician: Th certificate rector, pag		25. Was case referred to medical			26. Place of Dea	th (Check only or		03 20110
5	Physician: rthis certificaral director,	To Be	examiner? 1 X Yes 2 No Hospital: 1 In	patient 2 ER/Outpatie	nt 3 DOA Othe	er: 4 \(\text{Nursing H}	ome 5 🗆 Resid	ence 6 □Other (S	pecify)
0	ig Phys ter this neral dii		27. Manner of Death 28a. Date of 1 → Natural 5 □ Pending (Month	Injury 28b. Time of Injury	of 28c. Injur Worl	y at k?	28d. Describe h	ow injury occurred	
Ö	Attending r death. ector: After by the funer	atio	2 Accident investigation		M 1 🗆	Yes 2 ☐ No			
Division or Vital Records,	or Att	Certification:	determined 200. Place C	f injury - At home, farm, st g, etc. <i>(Specify)</i>	treet, factory, office		28f, Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Co	29a. Certifier 1 Certifying Physician: To the to (Check only one) 2 Medical Examiner: On the ban and mann	sis of examination and/or in	th occurred at the tir nvestigation, in my o	me, date and place opinion, death occu	, and due to the dirred at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
	o the ithin of the o the omple	Mec	29b. Signature and title of certifier		29c. License			29d. Date signed (Mo	
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7			30. Name and address of person who completed cause the complete cause and address of person who completed cause the complete cause and complete cause the complete cause and complete cause are caused as a complete cause and complete cause are caused as a complete cause and complete caused are caused as a complete caused and complete caused as a	of death (Item 23a) (Type	Print) Past A	ntietam	St L	lace istis	25, ma 2174
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J.	_		1 - State Registrar 1. Decedent's Name (First, M.	الماليات					unca	eon	Dealli		2. Date of D	Reg. No.	(U	JO	2 Time -61) J J
	Physicia	an	, , ,		_	1							Month	Day		Year	3. Time of	
	/Medic			dred		chne	ıder						April	08,		008	5:08	PM
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ija.	Director		Usual Residence of Decedent				/	4					April	8, 19	34	New	York	
	land ow		10a. State 10b. Cou				10c. City,	Town or Lo	cation							1	0d. Inside Cit	y Limits
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3	urs a al', c Exan	þ	3 ☐ Widowed 4 🛣 Divor	ed	If Yes, G Year or I	ive Dates:			1 ☐ Yes	2 No	Specify:				Specify.	Whi	.te	
0500-61	72 ho	ted	15. Dece (Specify only high	dent's Edu	cation)	Ţ	16a. Dece	dent's Usu	al Occup	ation during mos	et of work	ina	16b. Ki	nd of Bu	siness/Ind	dustry	
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0	of H of H if Iter		20a. Method of Disposition 1 ☐ Burial 2 【XCremation	n 3.⊟1	Removal from	State	20b. Pla	ace of Dispo metery, cre	sition (Na matory or	me of other plac	e) :		Date	20c. Lo	cation -	City or To	wn, State	
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			23a. Part1. Ente / he diseas shock, or /e rt failure.	or comp	lications that ne cause on	caused the	he death.	Do not en	er the mo	de of dyin	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Bety	veen
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ממ	tendi	an/	23b. Was decedent pregnant in the past 12 months?	10.2	23c. If yes, οι 1□Live		f pregnan		Ectopic p	regnancy	,			2		e of delive		·
	e des	sici	1 ☐ Yes 2 🛣 No		4□Preg 9□Unkr		me of de	ath 5	Other (s	pecify)					Mor	ıırı	Day Y	ear
	iclan: The law requires that the death certifica certificate has been signed by the attending phrector, page 2 should be detached for use as the	Physician/Med	9 Unknown								1 20		00 011					
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	The ate h	no:											perf	ormed? 21 No	d	eath? □Yes		
ומ	ertific ctor,	Be (25. Was case referred to med examiner?	ical							26. Place	of Death	Check onl					
>	hysic his ce I dire	To E	1 ☐ Yes 2M No		Hospital: 1 □	Inpatient	2 🗆 E	R/Outpatier	nt 3 🗆 D	Othe	er: 4□ Nu	ursing Ho	me 5 🔀 Res	idence (5 □Othe	er (Specify	1)	
-	ng Pi		27. Manner of Death 1 ☑ Natural 5 ☐ Per	ndina	28a. Date (Moi	of Injury	Year)	28b. Time o Injury	f	28c. Injun Worl	y at k?		28d. Describe	how injur	y occurre	ed		
101210	endi sath. or: A he fu	atic	2 Accident inve	estigation					М	1 🗆 '	Yes 2□	No						
ž	r Att	Certification:		uld not be ermined	28e. Plac	e of injunding, etc.	y - At hon (Specify)	ne, farm, str	eet, factor	y, office			28f. Location City or To	(Street and	d Numbe	er or Rura	l Route Numb	ber,
ב	Ital o	Se																
	Hosp thou Tune ely fil	cal	(Check only 2 Medi	ying Phy cal Exam	sician: To th iner: On the l	e best of basis of e	my know	rledge, deat on and/or in	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	e cause(s)	and mai	nner as st	ated. the cause(s))
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	one)		and mar	nner state	ed.						1					
	5 7 will	2	29b. Signature and title of cer	/	00	,				c. License						,	Day, Year)	
	10		Erone lo	rout	ales, V	W				D573	U4				+/10,	/ 2008	3	
			30. Name and address of pers					, , , , .	,								208	
			Eirene E. Ko 31. Date filed (Month, Day, Ye				108 's Signatu		nnec	cicut	: Ave	nue,	2nd F1	loor,	Ken	sing	ton, M	D
	Sta Registr			7 200		logistial	Joignall		el.									

DHMH 17 Rev 1/2001

			For State Registrar	State of M	laryland / De	partment of H			ene 008	14354
			Decedent's Name (First, Middle)	Last)				2. Date of Death		3. Time of Death
	Physicia		Wilbur	Т.	Smith			Month April	Day Year 15, 2008	5:05A. ^M
	/Medic Examin		4a. Fecility Name (If not institution,	give street and number	r)	4b. City, Town, or	Location of Death		4c. County of Deatl	
	ZAGITIII	•	College View Nu	rsing Cent	er	Frede	rick		Frederi	
	Funeral				ge (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,		nplace (State or Foreign untry)
	Director	}	Usual Residence of Decedent	TIAN 201	// Yrs.			Dec. 52,	1930 Mary	land
	and	1	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary f •h	ţŏ	Maryland Freder	ick	Thurmo	nt				1 ☐ Yes 2/CXNo
	7.28a	Funeral Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	h witl	a D	13127 Brice Roa	ıd		21788			USA	
	deat	ner	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S. 1	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
9	within 72 hours after death with the Maryland ene. Then "natural" or itams 23a or 28a-f ehow fre Madical Exemitier most be notified at		1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☐ If Yes, Give	χNο	1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
ğ	hours turai'	d b	15. Decedent	Year or Dates	16a De	cedent's Usual Occup	ation	1	6b. Kind of Business/	Industry
<u>.</u>	n 72	lete	(Specify only highes	t grade completed)	(G.	ive kind of work done	during most of wo	rking		
212	iene.	Completed by	Elementary/Secondary (0-12)	College (1-4o	Fa Fa	ctory Work	er		Tank Manu	ıfacturing
Maryland 21215-0036	be filed within 72 hours after death with the Marylar deliyysien. do hyygiene. do ther then "natural; or itams 23a or 28a-f show and, it a Madical Examinar mast be notified at evant, it a Madical Examinar mast be notified at	Bec	17. Father's Name (First, Middle, I	ast)			18. Mother's Na	me (First, Middle, M	laiden Sumame)	
<u> </u>	should be and Mental markad o umatic eva	ToE	Murray	David	Smi		May	Elizabe		one
a	2 should be filed v n and Mental Hygie is markad other t raumatic evant, Ib		19a. Informant's Name/Relationsh						City or Town, State, 2	Zip Code)
<u>ک</u>	and Shelth		Nancy Sweeney/Da	ughter		127 Brice		hurmont,	20c. Location - City or	Town. State
Baltimore,	permit. Pages 1 and 2 should Department of Heelth and Men Important: If Item 27 is marka any injury or other traumatic once.		20a. Method of Disposition 1 Deliberation 2 Cremation	3 Removal from State	.0	sposition (Name of trematory or other place	01.11			
Ë	permit. Pag Department Important: I any injury o	. 1	4 Donation 5 Other (Sp. 21. Signature of Funeral Service)		Stauffe	r Cremator 22. Name and Addre	· -		rederick. neral Home	
Ba	permit. Departrimports any info		DA DINI						it, Md 2178	
			23a. Fart1 Enter he disease or shock, or heart failure. List	complications that caus						Approximate Interval Between
п	Physician		Immediate Cause (Final disease or condition	Lun						Onset and Death
	/Medical		resulting in death)	Due to (of	/	+ 0.		X		
П	Examiner		Sequentially list conditions.	b. Chion	ic obsim	cture Pal	minary	Discare	<u> </u>	YCARS
	sit ad	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of):					
	end end II-tran	хап	that initiated events resulting in death) Last	c Due to (or a	as a consequence of):					
760,	wrequires that the death certificate be executed been signed by the ettending physicien end should be detached for use as the buriat-transit	alE								
687	ificate g phys			3 0.						
ŏ	n cert andin	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Petal death	3 □Ectopic pregnanc	v		23d. Date of de	
Vital Records, P.O. Box	death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	5 Other (specify)			Month	Day Year
o. O	at the by th stach	Phys	9 Unknown					32a Did tah	acco use contribute to	the cause of death?
s,	Attending Physician: The law requires that the death certifica r death. •ctor: After this certificate has been signed by the ettending phe by the funeral director, page 2 should be detached for use as it.	by	Part II. Other significant condition	A 1 . \	out not resulting in the	e underlying cause gi	ven in Pan I.	1 X Ye		robably 4 Unknown
50	requi	eted		1,0,000	1000					
Sec	elaw has t	Completed	/					24a. Was ar autops perforn	y prior to death?	utopsy findings available completion of cause of
a	n: Th licate r. pag						00.01	1□ Yes 3	No 1□Yes	2 □ No
⋚	sicial certificacto	o Be	25. Was case referred to medical examiner? 1 Yes	Hospital:	atient 2 FR/Outpa	itient 3 DOA Ot	/	eath (Check only one	e) ince 6 □Other (Spe	K(fv)
	Phy ar this aral d	٦. ا	27. Manner of Death	28a. Date of I		e of 28c, Inju		1	w injury occurred	(City)
on	nding ath. r: Afte e fun	atlo	1 Natural 5 Pendin 2 Accident investi	9	<i>Day Year)</i> Inju		Yes 2 □No			
Division of	ar deg	Certification	3 ☐ Suicide 6 ☐ Could determ	ined 200. Flace of	Injury - At home, farm etc. (Specify)	, street, factory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
ō	itel or rel Di led in	Cer								
	To the Hospitel or Attending Physicien: The lav within 24 hours effer death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medica)	g Physician: To the be Examiner: On the basis	s of examination and/o					
	thin 2 the the implet	Med	29b. Signature and title of certific	and manner	aidi o u.	29c. Licen	se number	2	9d. Date signed (Mon	th, Day, Year)
	ĭ¥ĭ8			Y		Den	6 6 2 2 3		4/15/08	
•			30. Name and address of person	who completed cause of	of death (Item 23a) (Ty		- 0-03		11.01	
	4		Dr. Praveen		96 Thomas		. Frede	erick, MD	21702	
		ate	31. Date filed (Month, Day, Year)	32. Reg			,			
	Regist	rar	API	(T 0 Thno	MANNEY Y	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month **Physician** 2008 16 1:45 Marie E. Shaffer April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Sykesville Fairhaven Nursing Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 250 F Maryland Director 213 03 4507 Jan 29, 1911 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Sykesville MD Carroll 10q. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21784 United States 7200 Third Avenue HC-124 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 s. ou ld be filed within Department of Health an Mental Hygiene Important; if item 27 is narked other than 'any Injury or other traunatic event, the Me any Injury or other traunatic event, the Me once. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daisy Fear Joseph Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Meadow Brook Lane Skillman, NJ 08558 William B. Shaffer/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 4-22-2008 | Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cerchial vascular accident. **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the burist-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 1∐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State

31. Date filed (Month, Day, Year) APR 1 8 2008

Sarante

29b. Signature and title of certifier

Third 7200 32. Ragistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kesville MD 21784

Ave

Registrar

29c. License number

1506500d

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11827 White Pine Drive, Hagerstown, Maryland 21740 20c. Location - City or Town, State Stauffer Crematory Inc 4/14/2008 Frederick, Maryland 1621 Opossumtown Pike, Frederick, Maryland21702 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 pairsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tohnson Dr. Frederick MD 21702 Shah temen 31. Date filed (Month, Day, Year) 32. Registrar Signature State **APR 16** 2008 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

10:00a

Birthplace (State or Foreign Country)

Maryland

Year

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of Ivia	iryiaiiu / L	Certificate of			Reg. No.	2008	143	57
	Dhusisis	0	Decedent's Name (First, Middle,	_ast)				2. Date of De Month	eath Day	Year	3. Time of De	eath
X.	Physicia /Medic			Lester Tue	l, Sr.			April	19	2008	2313	M
	Examin	er	4a. Facility Name (If not institution,				or Location of Death			County of Death		
-	Franci		Memorial Hospit 5. Social Security Number 6	al at Easto	n e (In yrs. last bir	thday) If Under 1 Year		8. Date of Bir	th	ellot 9. Birth	place (State or F	oreign
	Funeral Director		577-44-2264 Usual Residence of Decedent	1√2 M 2□ F		Yrs. Months Days	Hours Min.	(Month, Da March 2	, 1928	Wash	ington	DC
	yland yland at		10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City	
	e Mar Ba-f s	Director	Maryland Carol	ine	Pre	ston					1 Yes 2	*FINO
	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number 24365 Robins Cre	ek Road	4	10f. Zip Code 21655		4	Inited	en of What Cou L State	s of Ame	rica
	items	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?		13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No o Rican, etc.))- 1	4. Race - Ameri Black, White		
036	urs aft al", or Exami	by	1 ☐ Never Married 2 ☑ Marrier 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	1949	1 ☐ Yes 2 ☑ No	Specify:			Specify: Cauc	casian	
2	72 ho 'natur dical	eted	15. Decedent's (Specify only highest	Education grade completed)	16a	Decedent's Usual Occu (Give kind of work done	during most of wor.	king	16b. Kir	nd of Business/Ir	ndustry	
Maryland 21215-0036	within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	'life. DO NOT use retire Carpenter	ed)		Col	nstruct.	ion	
g 2		Be Co	17. Father's Name (First, Middle, La	est)		carquar	18. Mother's Nam	ne (First, Middle	, Maiden	Surname)		
<u>a</u> n	should be ad Mental marked c matic eve	To B	Guu	ewis Tuel			Elizabe	eth The	mas	Bettis		
ary	Short Short		19a. Informant's Name/Relationship			o. Mailing Address (Street						5.5
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Bettye C. Tuel 20a. Method of Disposition	Wife		4365 Robins		Date		racykar 		
Baltimore,	Pages nent of h int: If ite		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	□Removal from State		of Disposition (Name of ery, crematory or other pl tol Cremato	, <u>u</u>	/25/08		ver, De	•	
Balti	permit. Pages 1 and 2 Department of Health 8 Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service Li	up Mod	re	Name and Add	ress of Facility, I neral Howa Second Si	2, P.A.	Dento	n. Mary.	land 216	529
			23a. Part1. Enter the disease or c shock, or heart failure. List o	omplications that caused	the death. Do	not enter the mode of dy	ring, such as cardiac	or respiratory	arrest,		Approximate Interval Between	een
	Physician		Immediate Cause (Final disease or condition	a 30	cute	nyocar		ikRar	chia	2	Onset and De	eath P
	/Medical Examiner		resulting in death)		a consequence	,.	4	U	n 0 - 6	07		
5,	V.	er	Se uentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	oronary	arte	y a	ડાઇના	C		
	cuted nd ransit	Examiner	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c		·						
60,	ifficate be executed g physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequence	of):						
68760,	ifficate g phys as the	edical		d								
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certiwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat	h 3 □Ectopic pregnan 5 □ Other (specify)			2	23d. Date of deli Month	very Day Ye	ear
	that the poly detac	y Ph	Part II. Other significant condition	s contributing to death b	ut not resulting i	in the underlying cause g	iven in Part I.	23e. Did	tobacco u	se contribute to	the cause of dea	ath?
rds	equires en sig ould be	ed by						1 🗆	Yes 2[No 3□ Pro	obably 4 □Un	nknown
or Vital Records,	The law re te has ber age 2 sho	Completed					_		s an opsy formed? 2 2	24b. Were aud prior to death? 1 ☐ Yes	topsy findings av ompletion of cau 2 ☐ No	vailable use of
ļ ta	ertifica ctor, p	Be C	25. Was case referred to medical examiner?	N. Marie			26. Place of Dea		-			
7	hysic this ce	P	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie		utpatient 3 DOA				6 □Other (Spec	cify)	
ono	ding P h. After funera	tion:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigs	28a. Date of Inju (Month, Dation			uryat ork? ⊒Yes 2 ⊟No	28d. Describe	now injur	y occurred		
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of inj	ury - At home, f c. (Specify)	arm, street, factory, offic	е		(Street an own, State	d Number or Ru)	ral Route Numb	er,
_	Hospital 24 hours 25 Funeral stely filled	Medical Co	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	f examination a	ge, death occurred et the nd/or investigation, in m	time, date and place y opinion, death occ	e, and due to the urred at the time	e cause(s) e, date and	and manner es I place, and due	stated. to the cause(s)	
	To the To the To the Comple	Med	29b. Signature and title of certifier	141	110	_	nse number			te signed (Month		
			> = 7	AUT /	W	100	>04753	4	4	1/22/0	Sc	
			30. Name and address of person w				m _ n _ i	21/20				
	Str	ate	Wafik Zaki, M.D. 31. Date filed (Month, Day, Year)	920 Marke 32. Registr	ar's Signature	et, Denton,	raryland	21029				
	Regist			3 2008	and I	· Part						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 05.10 PM APRIL **Physician** 2008 Hilda Marie Thompson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Easton Hospital Memorial Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 69 10-12-1938 Maryland 219-34-3630 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director Marydel MD Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21649 17475 Henderson Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White à 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owned home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Kemp Clarence Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 114 Rebel Rd., Grasonville, MD 21638 Lou Ann Collier/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4/19/2008 4 □ Donation 5 □ Other (Specify) Mt. Olive Cem. Sandtown, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pippin Funeral Home, Inc. 119 W. Camden-Wyoming Ave. Wyoming, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 19934 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Days MRSA Pseudomoras Preumonia due to **Physician** /Medical Due to (or as a consequence of) **Examiner** Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of) attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed certificate has been rector, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No r this certificate and director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 1 → Natural 2 → Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Medical Certification: After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D66441 HD

or Attending Physician;

3altimore, Maryland 21215-0036

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THOMOSON, HILDA

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) 7 2008

KOLLI RAHESH

Naurel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Easton

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 19, April 2008 **EVELYN** VERDIRAMO 9:50 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Somerset Alice Byrd Tawes Nursing Home Crisfield 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🗓 F 83 202-16-3224 May 31, 1924 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 28a-f shov 1 √Yes 2 No Virginia Accomack Chincoteague Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6513 Pinedale Drive 23336 U.S.A. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 X Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Roscoe Helen Firkal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Teresa Aicher (Daughter) 60 Paul Street - Belvidere, NJ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Belvidere Cemetery 4/23/08 Belvidere, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatu Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, 1 Robert H. Bradshaw, LN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending ph for use as t 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I ₽ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2⊠No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

VIJAY 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARUMBUNAHAN 32. Resistrar's Signature HALL HIGHWAY, CRISPIELD, MD, 2181

19/2008

DHMH 17 Rev 1/2001

D 48098

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Walter King Wilson, III 2008 9:56p April 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5 Social Security Number If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 167 M 2 □ F Director 418-44-1431 70 April 28, 1937 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be 10 titled at 28a-f show 1 ☐ Yes 2 No Director Maryland Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4401 Buckthorn Court 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1956-88 1 ☐ Yes 2K No Specify: White à Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Engineer US Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter King Wilson, Jr. Jeanne Herman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Wilson/Wife 4401 Buckthorn Court, Rockville, MD 20853 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 M Removal from State Arlington Nat'l Cemetery July 16 Arlington, Virginia 2008 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd,. W. Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Entry the disease, or complications that builted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Subdural Hematoma /Medical Due to (or as a consequence of) Examiner Intracranial Hemorrhage Sequentially list conditions if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner onseque attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be tall hours after death.

Funeral Director: After this certificate has been signed by the attending physician stelly filled in by the funeral director, page 2 should be detached for use as the buris. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Coumadin-Induced Coagulopathy, Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1:00 a^M 1 □Yes 2 No 2 XAccident 4/11/08 Fall from standing 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4401 Buckthorn Ct. 4 Homicide At Home Rockville, MD 20853 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760 P.O. Records, of Vital Division 24 hours

Baltimore, Maryland 21215-0036

State Registrar

James W. MD Robey, 31. Date filed (Month, Day, Year)

title of certifier

mes

2008

29b. Signature and



MO



29c. License number

50113

29d. Date signed (Month, Day, Year)

April 15, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** ^{Day}1 2008 5:15 PM Martha Woodard /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7859 Crilley Road Apt 414 Glen Burnie Anne Arundel 8. Date of Birth Jan 14 1940 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1□M 2√0F Maryland 217-38-7784 68 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Glen Burnie Maryland Anne Arundel 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7859 Crilley Road Apt 414 21060 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🌂 ☐ No Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 11th 0 Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Joseph Cager Mary Jane Pack ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 6 0 Marva Hawkins(Daughter) 7859 Crilley Rd. Apt 414 Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4-15-08 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) z Name & Cooks Stor Facilit Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 B. Reese MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, reading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Exam Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed Fielus. End 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans attending p as certificate has t irector, page 2 s this Director: in 24 hours, the Funeral Directory filled in by

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death 1 ment of Heatih and Mental Hygiene.

ant: If fleam 27 is marked other than "natural", or items 23s ury or other traumatic event, the Medical Examiner must.

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

with the Maryland

within 2 Registrar

29a. Certifier 1 💢 CertifyIng PhysIcIan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be determined

29c. License number D 50470 29d. Date signed (Month, Day, Year) 4/14/08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death/(tem 23a) (Type, Print ATLURI 8109

APR 1 6 31. Date filed (Month) 2008

3 Suicide

4 Homicide

32. Pigistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Ma	rylan		partment of F ertificate of		Mental Hy	/giene Reg. No	711111	14366
	Physici /Medic		1. Decedent's Name (First, Middle, La Roger Lee Warren	,					2. Date of D Month April	eath 15	y 2008	3. Time of Death 01:30 A M
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of Deat	h	4c.	County of Death	
			Heritage Harbour Hea				Annapol				Anne Aru	
	Funeral Director		5. Social Security Number 6. S 300–48–9718 Usual Residence of Decedent	Sex 7. Age	58	ast birthda Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D 09/27)	av. Year)	9. Birth Cou Ohio	place (State or Foreign ntry)
	e Maryland 3a-f show tifled at	ctor	10a. State 10b. County Maryland Anne An	rundel		o, Town or						10d. Inside City Limits 1 □ Yes 2 No
	th with th 23a or 24 ist be no	Funeral Director	10e. Street and Number 2520 Riva Road				10f. Zip Code 21401			-	izen of What Cou ted Stat	•
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Merital Status 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1	0		3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗓 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: White	etc.
	iin 72 hou n "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade) Elementary/Secondary (0-12)	ducation		16a. De	cedent's Usual Occupive kind of work done b. DO NOT use retired	eation during most of wo	rking	16b. K	ind of Business/Ir	
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7	1 and 2 should be filed withi Health and Mental Hygiene. em 27 Is marked other than other traumatic event, the M	မ	Melvin Harry Warr			105 14-	iline Address (Otro-1		eve Mari			
2	and 2 sl ealth an n 27 Is r ner traur		Joanne W. Jackso				ailing Address <i>(Street</i> 07 River Ro					o Code)
נ	s 1 an f Heal item 2 other		20a. Method of Disposition		20b. P		position (Name of rematory or other place		Date On		ocation - City or T	own, State
2	Pages 1 nent of H int: If Iter iry or oth		1 ☐ Burial 2 ☐ X remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				Crematory	04/1	16/2008	Edg	ewater,	Maryland
Da	permit. Departn Importa any inju		21. Signatur Septice Licer	nsee			22. Name and Addre 2973 Solor					
	.A. 8.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	the death	. Do not e						Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	a. لـ سـه		CA	233					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a								
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,	sate be executed ohysician and the burial-transit		Cause (Usease or ligury that initiated events resulting in death) Last	CDue to (or as a	consequ	ience of):						
.C. DOY OF	ath certific ttending p or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal □ Fetal	death 3	3□Ectopic pregnanc) 5□ Other (specify) _	,		:	23d. Date of deliv Month	ery Day Year
623	w requires that the de is been signed by the a should be detached for	þ	Part II. Other significant conditions of EMPH455		not resu	lting in the	underlying cause giv	en in Part I.	5.1		_	he cause of death? bably 4 Unknown
		Completed				· · · · · · · · · · · · · · · · · · ·			24a. Was auto perf 1□ Yes	an ppsy ormed?	prior to co death?	opsy findings available impletion of cause of
	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea				
5 7	rthis ral dir	P.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatien		ER/Outpati 28b. Time	ient 3 DOA	4 Nursing F	fome 5 ☐ Res		6 ☐Other (Speci	fy)
	in one nospiral or Arganding Priysician: within 24 hours after death. To the Inneral Director. After this certifica completely filled in by the funeral director, I	Certification:	1 Actident 2 Accident 3 Suicide 6 Could not be	(Month, Day 28e. Place of injur	Year) y - At hoi	Injury me, farm,	/ Wor	k? Yes 2 □ No				al Route Number,
5	lo the hospital of Attend within 24 hours after death To the Funeral Director; , completely filled in by the f		4 Homicide	building, etc.		,			City or To	wn, State)	
	e nos 124 ho e Fun	Medical	29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of a and manner state	examinat	vieage, de ion and/or	arn occurred at the tir investigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time	cause(s) , date and	and manner as s d place, and due t	stated. to the cause(s)
	Vithir comp	Me	29b. Signature and title of certifier				29c. Licens				te signed (Month,	
0	Laske	اں	00		The Same		103	9037	_	AP 6	211 16	,2008
1.0	(By		30. Name and address of person who	completed cause of dea			e, Print)	al Pap				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 24, 2008 Year **Physician** Charlotte Elizabeth **Allen** 2:50 pM /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 2608 McComas Kensington Montgomery 8. Date of Birth (Month, Day, Year June 21, 1 . Social Security Number 137–40–3343 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 F 93 92 Yrs. Months Days Hours Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MO Jasper Joplin Director 1 Kes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 330 N. Moffet 64801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: Completed by If Yes, Give Year or Dates: Specify. 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker / Artist Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mitchell Ryland Grigg Gregg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregg Allen / Son 50 Saint Elmo Way, San Francisco, CA 94127 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Mt. Hope Cemetery 4/30/2008 Webb City, Missouri 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Avenue, Baltimore, MD 21230 21. Signature of Pageral Service Licensee Marsha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebroruscolar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be execu-Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ld be detached f Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division or Vital Records. Completed 1 Yes 2 No 3 Probably 4 Upknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performe To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature, and title of certifier 29c. License number B Will

Registrar
DHMH 17 Rev 1/2001

State

10c,

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

B

31. Date filed (Month, Day, Year) MAY 02 2008

WILKS

6095

32. Registrar's Signature

Baltimore Maryland 21215-0036

P.O. Box 68760. Division of Vital Records.

Residence of Decedent State 10b. County Cyland Baltimo: Street and Number 5 Dalton Avenue	street and number) 7. Age	(In yrs. last bir 81	rthday) If U Yrs.	City, Town, or I Dundalk Under 1 Year nths Days		rs. 8 Date of Bi	2008 4c. Co	Year ounty of Death	3. Time o	
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arital Status			10	Of. Zip Code 21224				n of What Coul	ntry?	
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Homicide determined Certifier 1 Certifying Physics	sician: To the best o	f my knowledge	e, death occ	urred at the time	e, date and pla	City or To	wn, State) e cause(s) a	and manner as	stated.	
one) Signature and title of certifier	and manner stat	ed		-				•	,	
The contract of the contract o	ther's Name (First, Middle, Last) Proge Burkhardt Informant's Name/Relationship (Ty, Tma Burkhardt Method of Disposition Burial 2 Cremation 3 B B Donation 5 Other (Specify) Grayure of Furnal Service License Actions of Heart failure. Vist only or diate Cause (Final se or condition ing in death) MALE: Was decedent pregnant in the past 12 months? By Dyes 2 Do Donation of Heart failure in the past 12 months? By Dyes 2 Donation of Heart failure in the past 12 months? Condition of Death of Heart failure investigation in the past 12 months? Condition of Death of Heart failure investigation of De	ther's Name (First, Middle, Last) Drge Burkhardt Informant's Name/Relationship (Type. Print) Ima Burkhardt wife Idethod of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Image: Part 1. Enter the disea, s. or complications that caused is shock, or heart failure. It is only one cause on each line diate Cause (Final se or condition ing in death) Part 2. Enter the disea, s. or complications that caused is shock, or heart failure. It is only one cause on each line diate Cause (Final se or condition ing in death) Due to (or as a condition ing in death) Due to (or as a death of the past 12 months? Image: Part 2. Due to (or as a death of the past 12 months? Image: Part 3. Due to (or as a death of the past 12 months? Image: Part 4. Due to (or as a death of the past 12 months? Im	Atter's Name (First, Middle, Last) Drige Burkhardt Informant's Name/Relationship (Type. Print) Ina Burkhardt Method of Disposition Burial 2 Ceremation 3 Removal from State Bayvi Donation 5 Other (Specify) Graphic of Furnal Service Licensee Cemete Bayvi Graphic of Furnal Service Licensee Cemete Ce	ther's Name (First, Middle, Last) orge Burkhardt Informant's Name/Relationship (Type. Print) Informant's Nam	ther's Name (First, Middle, Last) proge Burkhardt Informant's Name/Relationship (Type, Print) Ina Burkhardt Ina Burkhardt Informant's Name/Relationship (Type, Print) Informant's Name/Relationship	ther's Name (First, Middle, Last) orge Burkhardt moment's Name/Relationship (Type, Print) ma Burkhardt wife Method of Disposition Burial 2 Cremation 3 Removal from State Daton Avenue, D Bayview Crematory or other place) Bayview Crematory May Service Licenses Commence of commence of	there Name (First, Middle, Last) Trope Burkhardt The Burkhardt	there Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. Mailing Address (Street and Number or Rural Route Number, City or Tima Burkhardt 19. May 2, 2008 19. Date Core and core each time. 20. Name and Address of Facility. 21. Name and Address of Facility. 22. Name and Address of Facility. 23. Name and Address of Facility. 23. Name and Address of Facility. 23. Name and Address of Facility. 24. Name and Address of Facility. 25. Name and Address of Facility. 26. Name and Address of Facility. 27. Name and Address of Facility. 28. Name and Address of Facility. 29. Name and	there's Name (First, Middle, Last) The proper Burkhardt The prop	there Name (First, Middle, Last) Tron Worker 18. Mother's Name (First, Middle, Last) Tron Worker 19. Mother's Name (First, Middle, Maiden Sumanne) Elsie Edwards The Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May 19. Date Date of Deposition (First of Date) Bayview Crematory (Ameritary) The Part of Deposition (First of Date) Date of Deposition (First of Date) The part 12 morning of Date of Pelaco) Date to (or as a consequence of): Date

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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/Medica	L	Wilhelmi 4a. Facility Name (If no		nive street and	number)	Be.	1-Ta	_		n of Death	04	24		2008 by of Death	12:5	2a "
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	1	Michelle	Tavlo	r-Dauc	hter	1528	3 In	gran	n Te	err.	Sil	ver S	spr:	ing,	Md	20906
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ne Ho n 24 h ne Ful sletely	Medical	(Check only 2 one)	☐ Medical E	xaminer: Op/m	hasis of examariner stated.	nination and/or in	vestigatio	n, in my c	opinion, o	death occu	irred at the ti	me, date ar	nd place	e, and due to	the cause	n(s)
To th To th comp	ž	29b. Signature and tit	le of certifier	10 2			29	c. Licens	e numbe	er		29d. Da	ate sign	ned (Month,	Day, Year)	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 04 27 2008 3:56a. Barber Rosemary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 526 Lucia Ave Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F 212-58-4826 Director 07 52 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating and the mollified at 1 Kres 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 526 Lucia Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1

✓ Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2∑No Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry
Baltimore County 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Service Worker Public Schools 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Fields Eugene Barber ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Lucia Ave, Baltimore, Md Marlowe E. Wax-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State UD Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md Cedar Hill 5/2/08 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimaore, Md Signature of Funeral Service Licensee 21215 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sh. ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immer ate Cause (Final disse or condition resulting in death) **Physician** 5 Non Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Year Month 4 Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No certificate 2 No 1 ☐ Yes or Attending Physician: : After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COOPER NE 2. Registrar's Signature 31. Date filed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month April Year Day Barlow 0725PM Physician e994 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City The Johns Hopkins Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) Months Days Hours 70 218-42-1938 1 □ M 2 □ ₹ 4,1938 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show ns 23a or 28a-f show must be notified at Harford 1 ☐ Yes 2 TX No MD Darlington Director 10g. Citizen of What Country? 10f Zin Code 10e, Street and Number 21034 USA 2232 Glen Cove Road by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or item the Medical Examiner 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No White Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H Item 27 Is marked ott r other traumatic even Be William Y. Forbes Millie Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cindy Huovinen /daughter 90 West Kingston Park Lane Balto. MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō Department of I 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/1/08 Bayview Crematory Baltimore MD 21. Signatur Fyreral Service icentic 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cardiomyopathy Immediate Cause (Final disease or condition resulting in death) Is chemic 5-4-ears **Physician** /Medical Due to (or as a consequence of): Attero scherotre Cardiovas cular disease 10-15 years **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 □ No Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Linpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural

Certification: within 24 hours after death

To the Funeral Director:
completely filled in by the f

5 ☐ Pending investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide

6 Could not be determined

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

t 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

(Check only

29d. Date signed (Month, Day, Year) 29c. License number April 30,2008 RES-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAFIA N. S ALAKIA NO THE SOUND HEPKIND HOSPITAL GOO NORTH WOLFE STREET, BILTONOFE, MACHLAND

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month Physician Bates George 2:30 P M 04 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fayette Health & Rehabilitation Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**√3**M 2□ F 230-38-7432 76 Director May 7, 1932 VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. The Medical Examina. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1530 Mountmor Court 21217 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 250 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Specify: Black 1 ☐ Yes XX No 3altimore, Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) laborer Baltimore City Water Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Bates Lucy Bates ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Gloria Bates / Wife 1429 Mountmor Court: Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Zion Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 05/03/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of une Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. at J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death incrediate Cause (Final disease or condition resulting in death) Cornective Physician /Medical Due to (or as a conse vence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Attensilerotic the burial-tra Due to (or as a consequence of) physician Physician/Medical IF FEMALE use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1□ Yes 2☑No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

0

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mier-p Kiz

miln-

and manner stated.

KIBUNE

1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

031865

29d. Date signed (Month, Day, Year)

E joppa Rd Torson Md 21282

	Decedent's Name (First, Mide	per FH 0879 5 dle, Last) AIRD					2. Date of De Month	Day	2 008	3. Time of Death
al er	4a. Facility Name (If not instituti		nber)		4b. City, Town, or	Location of Death	APR		ounty of Death	
	UNIVERSITY OF			CENTER	BALT	MORE				
	5. Social Security Number 219–66–9852		7. Age (In yrs. la 45	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	h 10/9/ / / 08	1962 9. Birth Cou	place (State or Foreign ntry) MD
5	Usual Residence of Decedent 10a. State 10b. Count MD	n/A	10c. City	, Town or Loca	tion Baltimon	ce City				10d. Inside City Limits
II DIrector	10e. Street and Number	208 E. For	t Avenu	e	10f. Zip Code	21230		_	n of What Cou	intry?
by Funeral	11. Marital Status 1 XNever Married 2 Ma 3 Widowed 4 Divorce	Armed For arried 1 ☐ Yes If Yes, Giv	2 ⊠ No e		as Decedent of Hi Yes, specify Cuba ☐ Yes 2 ⊠ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		Race - Ameri Black, White,	
Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education nest grade completed) College (1	-4or 5+)	(Give ki life. DC		luring most of wori)	king		of Business/Ir	
5	12	1		Qu	mality Ir		(F) . A4: / //		nufactı	uring
מ	17. Father's Name (First, Middle Emmitt Baird					18. Mother's Nam Etta	ne (First, Middle, Thomas	Maiden Si	urname)	
္	19a. Informant's Name/Relation			1		and Number or Ru				p Code)
	Richard M. Ro	hrbaugh /		208 E.		enue, Ba	ltimore		1230 Ition - City or T	Taura Chata
	20a. Method of Disposition 12 Donation 5 Other	(Specify)	State Gle	emetery, crema en Have	atory or other place en Cemete	ery 5/2/	2008	Glen	Burnie	e, Maryland
	21. Signature of Funeral Service	e Licensee VICLO	Doda	Cha 150	ries L. 1 E. For	Stevens t Avenue	Funeral , Balti	Home more	Inc 212	230
	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	a. SEPS	SIS		the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death MoNTH
		b. PNEU	or as a consequence or a consequence or a cons	4						1 MONTH
al Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	CHROI		TILAT	OR DET	PENDEN	CE			5 MONTHS
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sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	1□Live b	come pf pregnal irth 2 □ Fetal ant at time of de own	death 3□E	Ectopic pregnancy Other (specify)			23	d. Date of deliv Month	very Day Year
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Certification: To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1	titions contributing to de CRSTRUCTION Cal Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	inth 2 Fetal ant at time of de own eath but not resure that the property of Injury th, Day Year) of Injury - At hong, etc. (Specify best of my know asis of examinatiner stated. MD / Ph e of death (Item	death 3 E S C S C S C S C S C S C S C S C S C S C S C S C S C S C C	Other (specify) Jerlying cause give AYELIT JOHA JO	26. Place of Dea or. 4 Nursing H	24a. Was auto perfect of the Ves th (Check only of the Ves 28d. Describe 28f. Location (City or To the Vertex at the time, and due to the the Vertex at the time, and the time, and the Vertex at the Vertex auto-	obacco use Yes 2 an an osy ormed? 2 No one) dence 6 how injury Street and wwn, State) cause(s) a date and p 29d. Date	Month e contribute to: No 3 Pro 24b. Were aut prior to codeath? 1 Yes Other (Specoccurred Number or Rui and manner as place, and due signed (Month) 27 2	the cause of death? bably 4 Unknow topsy findings availab ompletion of cause of 2 No ify) ral Route Number, stated. to the cause(s)

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** LORRAINE E. BROWN APRIL 27, 2008 11:58 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GENESIS ELDERCARE LOCH RAVEN PARKVILLE Birthplace (State or Foreign Country) if Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Director 86 MARYLAND 212-16-4871 8/13/1921 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at show 1 ☐ Yes 2 ☑ No Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or death y 8502 OAKLEIGH ROAD 21234 <u>USA</u> Funeral 14. Race - American Indian, r than "natural", or Items the Medical Examiner mu Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 Xo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE COUNTY Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL SYSTEM CUSTODIAN 12TH GRADE other 7 Is marked other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ROBERT ANDERSON MAISE TILLMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a WALLIS B. MEEKS/DAUGHTER 9534 GUNHILL CIRCLE. NOTTINGHAM, MD 21236 If item 27 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition jo 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or GARDENS OF FAITH CEM. 5/3/2008 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leaving to initial acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XÎUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 No 2**X** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3642 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4202 Baltimore 21204

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY

02

2. Registrar's Signature

			State of Maryland / Department of Hear 1 - State Registrar Certificate of De		Hygiene 2008	3 14371
			Decedent's Name (First, Middle, Last)	2. Date of	Death	3. Time of Death
	Physici: /Medic		Peggy J. Chandler	Apri	Day Year	8 4:00 PM
The same	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc		4c. County of Deat	h
			3221 Putu Hill Avenue Parki	ville.	Coalt	imore
	Funeral	П	5. Social Security Number 6. Sex , 7. Age (In yrs. last birthday) If Under 1 Year If	Under 24 Hrs. 8. Date of (Month,		hplace (State or Foreign untry)
	Director		24-24-5702 10 M 24 80 Yrs.	Octa		aryland
pue	A :		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
faryl	Sho	ō				1 □ Yes 2 No
the A	28a-	rect	106. Street and Number 10f. Zip Code		10g. Citizen of What Co	٧
with	3a or	Ö	200, 0 11 1111 0	24	115A	ono,,
3-UUSO 72 hours after death with the Maryland	ms 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa		No- 14. Race - Ame	rican Indian,
uffer o	or iter		1 Never Married 2 Married 1 Yes 2 No		Black, White	
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aryland 2121 should be filed within	d Me mark matic	ျှ	19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Mailing Address (<i>Street and</i>	VIOIET	Haines	Tin Contail
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re, n	f Hea		20a. Method of Disposition 20b. Place of Disposition (Name of	hil Hvenue	20c. Location - City or	
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be D	Depar Impor any ir		Evans Fined	al Chapel & C	remation Services	ces Parleone
			23a. Part1. Enter the disease, or complications that caused to a dath. Do not enter the mode of dying, so shock, or heart failure. List only one cause on each line.	uch as cardiac or respirator	ry arrest,	Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition a.) ewent of cause or condition a.	x		Onset and Death
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		<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
nted	ig Jul	ä	Cause (Disease or injury			
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res th	signed I	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		id tobacco use contribute to	
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Atter	r dea ector by the	<u>ii</u>	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office		n (Street and Number or Ru	ral Route Number,
5 0 E	s arre	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or	Town, State)	
DIVISION OF VICE DECOMES, F.O. BOX 60/00, P.O. BOX 60/00, P.O. BOX 60/00, P.O. BOX 60/100,	within 24 houts after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, of the desired forms of	on, death occurred at the tin	ne, date and place, and due	to the cause(s)
To the	To the	Me	29b. Signature and title of certifier 29c. License nur	mber	29d. Date signed (Month	ı, Day, Year)
	112		Ihomas truciane D24	t334	05 01	2008
í	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4940	Eastern Ave	enve
,			71 Data filed (Marth Day Mar) 120 February Streeture	Baltin	noce, maryla	nd 21224
	Stat Registra		29b. Signature and title of certifier 29c. License nur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License nur			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician TON 2008 listeR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Days Min. ad 10 M 2□F Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Heath and Mental Hygiene.
ortant: If frem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working (life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2104 Department of Hea Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signatu/e of Funeral Service Licensee Simberly ERVICES-DELAN HILDERG Approximate Interval Between Onset and Death 23a. Part1. Enter the discass, or conflict ons that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail or a first only one cause on each line. Immediate Cause (Final ARDIOGE Physician WIC HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** NEARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 TYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

the death certificate be executed attending physician and signed by the The law requires that certificate or Attending Physician; this filled in by the funeral death. Director: To the Hospital o within 24 hours aft To the Funeral D

death with the Maryland

Maryland 21215-0036

Baltimore,

1' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

Medical

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cau e ol death (Item 23a) (Type, Print)

P. D. 500 Upper Registrar's Signature he Sapeake Dr. Beldig MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** William 12:15 A^M Austin Cuffley May 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Health & Rehab Glen Burnie der 1 Year | If Under 24 Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 □ F 216-01-7166 Director MD April 01 Usual Residence of Decedent or 28a-f show a notified at 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or edical Examiner must be r 308 Creek Blvd. 21122 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: δ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Slaughterer Livestock 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental William Cuffley Α. Sr. Frances Ε. Knipple nt of Health and M :: If Item 27 is mar or other traumat 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary V. Cuffley 308 Creek Blvd., Pasadena, MD 21122 (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May Date 02 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or Maryland Veterans Cem 2008 Crownsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part. Enter the disease, or complications that caus shock, or heart failure. List only one cause Bo not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ed the death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as 1 attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. nis certificate has been signed by the a director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? this certificate 1□ Yes 2□ 116 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined The printing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the cause (s). 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and Atle certifier 29d. Date signed (Month, Day, Year)

State Registrar

MAY 0 2 2008 DHMH 17 Rev 1/2001

Aatya Chov o 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

57028

Avenue #231 Annapolis

05-02-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 4 **Physician** 2008 Lincoln M. Cannady 1:10 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 601 E. 43rd Street N/A Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 8-4-1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex 14∑M 2□F **Funeral** Months Days Min Hours 238-42-3414 81 N.C. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Director N/A Baltimore MD death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 601 E. 43rd Street Funeral USA rai", or Items 2 Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced "natural". Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel N/A Laborered 10th grade th and Mental Hygus marked others other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cannady Creasie Smith Benjamin Pages 1 and 2 should nent of Health and Mer P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 | Balto, MD 21212 601 E. 43rd Street Meta Cannady-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-3-2008 Balto, MD Druid Ridge Cem 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H Ε. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nola MOS-415 disease or condition resulting in death) Carcel /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be exeguted and Due to (or as a consequence of): physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify). Division or Vital Records, P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe page death? 1 ☐ Yes certificate 1□ Yes 2□ No 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 ☐Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ol or Attending Fafter death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the ...
within 24 hours.
To the Funeral D' 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) HORIBA 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

MO

32 Registrar's Signature

BALTIMORE

30. Name and address of person who completed cause of deam (Item 23a) (Type, Print) MARCH

HORIBA

31. Date filed (Month, Day, Year) MAY 0.2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jamal Alexander Cross State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Alexander Cross 0410 hrs Medical Examiner Jamal April 30, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7637 WB&A Boulevard Glen Burnie Anne Arundel 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Wash. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24Hrs. **Funeral** 09/29/1989 Months Days Hours 216-25-5715 Director 19 Country) 1 X M 2 F D.C. Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Lanham P.G. MD. 1 X Yes 2 No 28a-f show notified at once. after death with the Maryland Director 10e. Street and Number 10g, Citizen of What Country 10f. Zip Code 2910 Mueserbush Court 20706 U.S.A. items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married X No Yes Specify: Black Yes 2 X No specify: 3 Widowed Divorced If Yes, Give Year \$ Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura injury or other traumatic event, the Medical Examinium or other traumatic event, the Medical Examinium or other traumatic event, the Medical Examinium or other traumatic event, the Medical Examinium or other traumatic event, the Medical Examinium or other traumatic event, the Medical Examinium or other traumatic event, the Medical Examinium or other traumatic event, the Medical Examinium or other traumatic event, the Medical Examinium or other traumatic event. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cynthia Monsell Melvin A. Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Berry/Mother 2910 Mueserbush Ct. Lanham, Md. 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Laurel, Md. 5/6/08 Donation 5 Other Specify: Maryland Nat. Cem 22. Name and Address of Facility The House of Williams 814- Upshur Street, N.W. 21. Signature of Funeral Service Licenses Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical x AMENDED 8 per fh g879 5-7-08vt signed by the attending physician be detached for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 V Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ examiner? Hospital: 1 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this Inpatient 2 1 🗸 Yes ۵ No After 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification Apr 30, 2008 Subject passengerr of vehicle in motor vehicle __ Natural 0410 hrs Yes 2 V No Pending To the Funeral Director: completely filled in by the accident 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide 7637 WB&A Boulevard, Glen Burnie, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 30, 2008 Name and address of person who completed chose of death (Item 23a)

Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year Louis C. Causey Month **Physician** 13:52PM Apn 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HOS PItal Bourmose St Agres If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days 1 □XM 2 □ F Months 215-42-7404 66 Dec.29,1941 Director MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Harford Director Joppatowne 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 400 Foster Knoll Drive 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∏ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 ☐ No 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Repair Radio/TV 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental. Important: If Item 27 is marked any Injury or care. Louis R. Causey Rosalie Porter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Causey /father 2516 Taylor Ave. Balto. MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Parkwood Cemetery 5/3/2008 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 ns that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part . Enter the disease, or complete shock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition stage chronic Obstructive lung disease **Physician** 2 years disease or condition /Medical Due to (or as a consequence of): Examiner Collins week Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine tailuse Renal i week Due to (or as a consequence of). Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribate to the cause of death? þ 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident pletely filled in by the 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

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State Registrar

Medical

29b. Signature and title of certifier rockely

29c. License number 20965

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BODDU. 9005 CATON AVENUE, ST AGNES HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year) MAY 0 5 2008

NEERATA

29a. Certifier

32 Registrar's Signature

)en	ny Wayne C	1	- For State	f Maryland /		rtment of tificate of			Menta	al Hyg		g. No.	200	18 1437
	Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)			 					Date of Deat Month	h Day	Year	3. Time of Death 0810 hrs
VIe:	dical Exami			RISTIAN		La	- City T	our or la	ocation of		April 28, 2		County of Deat	
			4a. Facility Name (if not institution, give s 24 Malvern Drive	treet and number)		4	Elktor		callon of	Death			ecil	
	Funeral	-	Social Security Number 6. Sex	7. Age	(In yrs. la	ast birthday)	If Unde	r 1 Year	If Under	24Hrs.	8. Date of Birt	h (MM/I	DD/YYYY) g. Bi	rthplace (State or
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	within ner the	Completed	12 17. Father's Name (First, Middle, Last)			Tree T	rım		8 Mother's	Name (First, Middle, I			e Service
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	, MD 21215-0036 cand 2 should be filed within 72 hours after death with the Maryland cand a Montal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medisal Examiner must be notified at once	To B	19a. Informant's Name/Relationship (Type			19b. Mailing	Address						ity or Town, Sta	te, Zip Code)
	MD and 2 sho alth and m 27 is aumatic		Rose Givens / Moth	er									land 219	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta		Place of Dispos crematory or oth			etery,		Date	20c.	Location - City	or Town, State
	Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:		B€	el Air M								Maryland
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		W 16	23a. Part I. Enter the disease, or complete	ations that caused	the death	Do not enter the	17 C	okes	bury	Road rdiac or	d, Abii respiratory ari	ngdo rest. sh	on, Mary	Approximate Interval
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	Box 68760, e death certificate be the attending physic ed for use as the bur	n/M	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pre		tal death	3	Ectopic	pregnar	псу	25	Month Month	Day Year
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	Division of Vital Records, P.O. Box 6876 rial or attending Physician: The law requires that the death certificat urs after death. Fal Director: After this certificate has been signed by the attending physical by the funeral director, page 2 should be detached for use as the	Completed	neace and enronce	arcono acc							24a. Was			autopsy findings available
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	OD endin sath. or: A	흝	1 X Natural 5 Pending 2 Accident Investigation		cui,			1_1	es 2					
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1.	Division of Vital Rec vital and the Hospital or Attending Physician: The lawthin 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	cal	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	in: To the best of m On the basis of exa	y knowle	edge, death occu and/or investiga	rred at th	ie time, da ny opinion	ate and pla , death oc	ace, and curred a	due to the cau t the time, dat	use(s) a e and p	and manner as s place, and due to	stated. o the cause(s)
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1	OK perd		30. Name and address of person who c	ompleted cause of	death (Ite	em 23a)	!_							
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Attending Physician:

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 27 **Physician** 3:00p. M Dixon Μ. 04 2008 Virginia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖫 F 215-28-6446 01 12 33 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ∐Xves 2 □ No Director NA Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21239 U.S.A. 1417 Stonewood Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 No Specify: Specify: þ Black 3

Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mean Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Registered 4yrs+ Nurse 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hannah Barnette William Jackson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1618 Jeffers Road, Towson, Md 21204 Diane Diggs-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Murial 2 Cremation 3 Removal from State 5/3/08 Pikesville, Md 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West aru 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lears Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached ☐Yes 2 No □Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has funeral director, page 2 s autopsy perform 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. spital or Attendi nours after death. neral Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier

State Registrar

31. Date filed (Month.

6701

Registrar's Signat

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

Charles St. Balto. Md Z120x

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Daniel Jerome Daniloski	State of Maryland / Department of Health and Mental Hydis

aniei J			1- For State Registrar	te of Maryland		tificate of		and w		Re	eg. No.	008	3 1437
	Physici: I Exami		1. Decedent's Name (First, Middle Daniel J. Dani							2. Date of Deat Month April 29, 2	Day Year		3. Time of Death 1055 hrs
			4a. Facility Name (if not institution	, give street and number)		4			ion of Death		4c. County o		+1.4
F	uneral		591 Bowleys Quarters 5. Social Security Number		e (In yrs. la	ist birthday)	Middle If Under		Under 24Hrs	s. 8. Date of Birt	th(MM/DD/YYYY)		
	irector		215-50-8345	1XM 2_F 58	3	Yrs.	Months	Days H	lours Min	3-29-1	1950	Foreign Cour	
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2-00	Hygiene. I other than,		17. Father's Name (First, Middle, L	_ast)		DISADI	.eu	18.Me	other's Name	e (First, Middle, !	Maiden Surname		
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O 3	일 후 약 출 🛭		Christine Barke			189	4 Yal	ona R	d.	Balto.	Md. 212	34	
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ς 687	ending 1	Giai	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at		2 Fe	tal death her (Speci		ctopic pregn	ancy	Month	Da	ay Year
. B oy	y the att	Physi	1 Yes 2 No 9 Unkr	9 Olikilowii					in Port I	220 Did to	phase use contr	ibute to th	ne cause of death?
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Division of Vital Records,	rife faw fequir icate has been s page 2 should I	Completed by								24a. Was	osy p		opsy findings available impletion of cause of
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/ital	this certif I director,	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2	ER/Outpatient	_	Otho	eath (Check	ng Home 5	Residence 6	✓ Other:	Scene
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Division of Vital	within 24 hours after death To the Funeral Director: completely filled in by the	Medical		vsician: To the best of miner:On the basis of exa									
	wit To	Mec	29b. Signature and title of certifier	and manner stated.				License nur			29d. Date sign		
			Calura	44	7	>		O.C.M.E			April 30, 20	800	
	1		30. Name and address of person v Zabiullah Ali, M.D. A	vho completed cause of d ssistant Medical Ex	,	ŕ	n Street	Baltimo	re, MD 21	1201			
	St Regis		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	re Coaste	,	*		 ,			

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		1	POF	partment of Health and Nertificate of Death	Reg. No.	
	Physicia	เท	1. Decedent's Name (First, Middle, Last) Robert William Dungan		2. Date of Death Day 4/26/200	3. Time of Death 1/45 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 401 2nd Avenue S.W.	4b. City, Town, or Location of Death Glen Bur		anty of Death Anne Arundel
Ī	Funeral Director		5. Social Security Number 212-48-1085 6. Sex 1 ☑ M 2 □ F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 7/26/47	Birthplace (State or Foreign Country) MD
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County Anne Arundel	Location Glen Burni	e	10d. Inside City Limits 1 ☐ Yes 2점 No
	3a or 28a	Funeral Director	10e. Street and Number 401 2nd Avenue S.W.	10f. Zip Code 21061	10g. Citizer	n of What Country? USA
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show simportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exami, ar must be notified at an ance.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 No Army If Yes, Give Year or Dates: Vietnam	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Tyes 2XXIII Specify:	Rican, etc.)	Race - American Indian, Black, White, etc. Decify: White
21215-0036	within 72 ho ene. than "natur he Mudicul	Completed	(Generally highest and completed)	cedent's Usual Occupation we kind of work done during most of work DO NOT use retired) State Employe	king	of Business/Industry State of MD
land 2	id be filed ental Hygi ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) Donald Dungan	18. Mother's Nam	ne (First, Middle, Maiden Su Funk	umame)
Maryland	nd 2 shou lith and M 27 is mar	-	19a. Informant's Name/Relationship (Type, Print) Gloria A. Dungan / Wife 401	ailing Address (Street and Alymber or Ru 2nd Avenue, Glen	ral Route Number, City or T Burnie MD 210	own, State, Zip Code) 061
Baltimore,	Pages 1 ar nent of Hea int: If item iry or other		Cometery, C	position (Name of rematory or other place) sville VA Cem. Apr		tion - City or Town, State Crownsville MD
Balti	permit. Departm Importa any inju	l s	21. Signature of Funeral Service Licensee Victor Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	haries L. Stevens 501 E. Fort Avenue		Inc. MD 21230 Approximate
8760, V	Cate be executed by Sician and bub sician and physician and the parian-transit in the parian-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	votic Heart	DISCAS	
.O. Box 68	death certifi e attending sd for use as	by Physician/Med		3 Ectopic pregnancy 5 Other (specify)	23	d. Date of delivery Month Day Year
Δ.	o o		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death? No 3 Probably 4 Unknown
Vital Records,	e law has b je 2 st	Completed			24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	siclan: certific rector,	Be	25. Was case referred to medical examiner? 1 ★Yes 2 □ No	Other	ath (Check only one) Home 5 Kesidence 6	□Other (Specify)
on of	ding h, After fune	ıtlon: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Tim Inju	e of 28c. Injury at	28d. Descri e how injury	
Division	P # in in in	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dependence on the control of the past of examination and/or and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the cause(s) a urred at the time, date and p	and manner as stated. blace, and due to the cause(s)
.	To the within 2 To the complet	Ň	29b. Signature and title of certifier Deput	29c. License number		signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (item 23a) (Ty	pe, Print) 695 A	t 4	21035
	St Regist	ate rar	37. Date filed (Month, Day, Year) 32. Registrar's Signature	land o		

Baltimore, Maryland 21215-0036 4.27.08 DEL BIANCE, ANICH

Box 68760,	
P.O.	Last Man
Records,	4
fVital	
Division o	0
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician APRIL 27, 2008 7:36 P. ANNA B. DEL BIANCO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TOWSON BALTIMORE GILCHRIST CENTER 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 💢 F 212-01-6871 MARYLAND 88 12/25/1919 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Extrairest that selffled at 1 ☐ Yes 2 No Director MD BALTIMORE PARKVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 8507 OAK ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 DXNo Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE SCHOOL NURSERY SCHOOL TEACHER 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi FRANK KUEHNE ADA MOHR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is n AIMEE N. HOLLAND/GRANDDAUGHTER 9960 TIMBERKNOLL LANE ELLICOTT CITY, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State injury or Important: If any injury o GARDEN OF FAITH CEM. 5/1/2008 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician week resulting in death) /Medical Due to (or as a consequence of) xaminer Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): ner the attending physician and hed for use as the burial-transil Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2XNo 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be 1 ☐ Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 TNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 冠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 02 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year **Physician** 1:00 AM M April 29, 2008 Sammy J. Ergonis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/14/1925 9. Birthplace (State or Foreign Country)

WV 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. Days Months Hours 1 M M 2 □ F 82 Director 234-32-0824 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20016-4201 Butterworth Place NW Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 1 Mayes 2 No If Yes, Give Year or Dates: WW ↓ 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Barber Shop filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Barber d 2 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarafina (Unavailable) John Ergonis ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 240 Carr Ave. Clarksburg, WV 26301-Ann Secreto/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory May 2, 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services M60382 Stiple Lolin 933 Gist Ave. Silver Spring, Maryland 20910ren Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hypoxic Physician Respirator disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Prevmonia Health - come if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine A Pie burial-transit resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as 1 attending p IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the g Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown reidism 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No page certificate ! 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

o Division of Vital Records, SAMMY RGONIS

Baltimore, Maryland 21215-0036

al or Attend s after death i Director: / filled in by within 24 hours a

To the Funeral C

completely filled

State

Registrar

Medical

29b. Signature and title of certifier MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D 0062167

4129/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKHOND HOSSEIN

8600 OLD GEORGETOWN RD. BETHESDA MD

31. Date filed (Month, Day, Year) MAY 0 2 2008

29a. Certifier

(Check only one)

ASL MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Physician 28, 2008 April 7pm Eggleston James /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4918 St. George Ave. Baltimore der 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Months Days Hours 1 M 2 F 80 April 15, 1928 Va. Director 216-20-7404 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Xes 2 ☐ No Director Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U . S . A . 14. Race - American Indian, Black, White, etc. 21212 by Funeral 4918 St. George Ave. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker **PushOperator** 10th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (၉ Wirt Eggleston Mary Elizabeth Watson Edward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. George Ave. Balto., MD 21212 ition (Name of Date 20c. Location - City or Town, State Alma Maude Eggleston/Wife 4918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State GarrisonForestVetCemMay6,2008OwingsMills,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Conge 11/18 **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of) **Examiner** Sequentially list conditions, if any, leading to mine distances. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Was a autopsy performed 1☐ Yes or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division (Month, Day Year) Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed ca

MAY 02

North

2008

DHMH 17 Rev 1/2001

use of death (Item 23a) (Type, Print)

32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as section.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10f perfh 8879 5-2-08 vt. State of Maryland / Department of Health and Mental Hygiene and an amend State of Maryland / Department of Health and Mental Hygiene and an amend State of Maryland / Department of Health and Mental Hygiene and a state of Maryland / Department of Health and Mental Hygiene and a state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Health and Mental Hygiene and the state of Maryland / Department of Hygiene and Hygie Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year April 30, 2008 Theodore F. Foti Sr. 5:55 A. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Marilyn's Home for the Aged Snow Hill Worchester If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months 1**%∑**M 2□ F 91 Yrs. 2/14/1917 066-14-2407 New York, New Yor Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Berlin Worchester 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21811 7 Decater Street 21211 of America 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 25 No Specify: Specify: white 3₹Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene Important: If item 27 is marked other than "naturat; or Iteme 23s any injury or other traumatic event, the Medical Examinat right any pings. 21215-0036 Baltimore, Maryland

Physician

/Medical

Examiner

10a. State

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Angelo Gennerelli

Theodore F. Foti Jr./ son

1 ☐ Burial 2 © Cremation 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type, Print)

* 4 □ Donation 5 □ Other (Specify)

21. Signature Juner I Service Licensee

Funeral

Director

or 28a-1 show

Director

Funerai

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Completed

Be

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Pnysician /Medical Examiner

sicien and The law requires that the death certificate be executed physicien as the attending | signed by the at the detached for certificate To the Hospitel or Attending Physicien: this After thi funeral death, s after death

Box 68760

P.0.

Division of Vital Records.

Certification; In by the Medical completely

23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Examine that initiated events resulting in death) Last Physician/Medicai IF FEMALE: 9 ☐Unknown þ Completed Be 1 Yes 2 No ို 27. Manner of Death

1 Natural 2 Accident 3 ☐ Suicide

Sequentially list conditions, if any, leading to thin ediate cause. Enter Underlying Cause (Disease or injury 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No

25. Was case referred to medical examiner? 5 Pending investigation 6 Could not be determined 4 | Homicide 29a. Certifier

4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ADVANCED

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

College (1-4or 5+)

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)

Engineer

20b. Place of Disposition (Name of

cametery, crematory or other place) Evans Funeral Chapel- Bel Air

ALZHEIMER'S

D62172

23d. Date of delivery Day Month

Glen L. Martin

20c. Location - City or Town, State

Forest Hill, Marylan

Approximate Interval Between Onset and Death

Year

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 26. Place of Death (Check only one) 6 X ther (Specify) X N G

Other: 4 Nursing Home 5 Residence 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

18. Mother's Name (First, Middle, Maiden Sumame)

1 Stillway Court Cockeysville, Maryland 21030

eaceiul Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093

Mary unk.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

May 4,

UEMENTIA

2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Eccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/30/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATYAL, M.D. 1604 MARKET ST POCOMOKE CITY MD 21851

28b. Time of

Injury

31. Date filed (Month, Day, Year) 0 2 2008

SHARAD

R

Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

State

Registrar

within 24 hours a To the Funerel D

			1 - For State	State of Marylan		rtment of H			() (nne	11.385		
E	Physici	ş an	Registrar 1. Decedent's Name (First, Middle, Las		~	()	Death	2. Date of De	ath Day	Yeer	3. Time of Death		
(la	/Medi	cal	Jessie 4a. Facility Name (If not institution, give		orsy		or Location of Death	APRIL	28	2008 ounty of Death	10:45 M		
	Examir	ıer	LORIEN-BEL			BEL A				ARFOR	-D		
	Funeral Director		5. Social Security Number 6. Se		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da			lace (State or Foreign		
	e Maryland Sa-f ahow Illied al	ctor	10a. State 10b. County MD Harfo	rd 10c. City	y, Town or Loc	Bel Air				11	0d. Inside City Limits 1 ☐ Yes 2 No		
	h with th	ai Dire	10e. Street and Number	EN Road		10f. Zip Code	1015		10g. Citize	n of What Coun	try?		
9036	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "natural", or items 23a or 28a-1 ahow avant, the Medicel Evanting must be notified at	t by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1f		dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)		Race - Americ Black, White,	an Indian, atc.		
1215-0036	within 72 he ene. than "natu tha Medical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) Coltege (1-4or 5+)	(Give A	ent's Usual Occup kind of work done OO NOT use retired	during most of won d)	king	16b. Kind	of Business/ind	lustry		
Maryland 21	ould be filed with Mental Hygiene arked other than atic avant, Len	To Be Co	17. Father's Name (First, Middle, Last)	File	1/800	4) HORI	18. Mother's Nam	ne (First, Middle,	Maiden St	umame)			
a)	Pages 1 and 2 should nent of Health and Men int: If Item 27 is marke iry or other traumatic		19a. Informant's Name/Relationship (7	4h - 56n	60/	Address (Street ition (Name of atory or other place		ral Route Number	lumi	tion - City or To	Code) 21045, wn, State		
Baltimor	permit. Pac Department Important: any injury once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Dicen	Evui	75 MUNE! 22.	Name and ddre	ss of Eaculity	108. FOROST		st Hill 40210 B'on SE	D. CES-BOR		
	Physician /Medical Examiner	ner	23a. Parti. Enter the disease or composition shock, or heart failurg. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	. > 0	UTIA Juence of):	F ル ム		or respiratory ai	rest,		Approximate Interval Between Onset and Death		
8760,	ate be executed the state of the parties and the purial-transit	dical Examiner											
P.O. Box 6	The law requires that the death centificate be executed the has been signed by the attending physicien and sage 2 should be detached for use as the burtal-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □	Ectopic pregnancy Other (specify)	,		230	d. Date of delive Month	ry Day Year		
	w requires that been signed t should be det	by	Part II. Defice significant continuous contributing to death but not resulting in the underlying cause given in Part I.								accoluse contribute to the cause of death?		
Vital Records,		Completed	CONGESTIVE HEART FAILURE CHRONIC OBSTRUCTIVE LUNG DISEASE, ANASARCA 24a. Was an autopsy performed? performed? death? 1 yes 20 No 1 yes 20 No										
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea						
ion of	ding h. After fune	ation: To	27. Manner of Death 1 2 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 1 28a. Date of Injury (Month, Day Year)	28c. Injur Wor		ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred						
Division	or Al	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	e Hospital 124 hours a re Funerel l letely filled	Medicai	29a. Certifier 1 Certifying Phy (Check only one)	ysician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or inve	occurred at the tine stigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) ar date and pl	nd manner as sta ace, and due to	ated. the cause(s)		
	To the within 2 To the comple	W	29b. Signature and title of certifier	13 011		29c. Licens			29d. Date s	signed (Month, L	Dey, Year)		
	Ĭ		30. Name and address of person who o	completed cause of death (Item	23a) (Tyne P	D45	344	4	1/30	12008			
	Sta		SURESH DHANJI 31. Date filed (Month, Day, Year)	completed cause of death (Item ANI MD 622 B. Registrar's Signary	S. UU	ION AVE	E, HAVR	EDEGR	ACE,	MDS	11078		
	Registr	ar:	MAY 0 2 200	S KARAGE SE	1								

Forsyth, Jessie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2, Date of Death Month **Physician** 170 /Medical County of Death give street and number) Examiner If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) MAY 3, 1924 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 X M 2 □ F CAROLINA S. 577-36-1891 83 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 XYes 2 No must be notified Director N/A BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21216 U.S.A. 2030 BRADDISH AVENUE or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Eventions. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) GENERAL Elementary/Secondary (0-12) College (1-4or 5+) REFACTORY PRESS OPERATOR 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FREDERICK COAKLEY N/A SHELLIE ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRADDISH AVENUE, BALTIMORE, MD. FLORENCE FREDERICK/ WIFE 2030 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) DULANEY VALLEY MEM. 5/5/08 TIMONIUM, MARYLAND 21. Signature of Funeral Sovice Licensee 22 Name and Address of Facility JLLY & ZEILER INC. FUNERAL HOME 901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical be to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ocur dir Physician/Medical IF FEMALE: yes, outcome pf pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2. No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Tyes After this in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Centifier

State Registrar

31. Date filed (Month, Day, Year)

nd address of person who



completed cause of death (Item 23a) (Type, Print)

(1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
APPLO 1717/8, per H1, 68/9, 5/8/08, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Flores 2009 5: 35 M M 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bal 4 more Sonky 16 (nombell Genesis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 1/9/1920. Birthplace (State or Foreign (Month, Day, Vear) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F Days Months Director 212-30-5586 88 4/9/1029 OHIO Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23e or 28a-f show digal Examiner out be notified at 1 ☐ Yes 2 XNo Director BALTIMORE HUNT VALLEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 WINTERBERRY COURT 21030 USA Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify: Specify: 3 X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF PLANT TOURS BETHLEHEM STEEL 12TH GRADE othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ပ GINES FLORES ELVIRA CONTIOSO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 itam 27 other tra ALLISON TRAN/DAUGHTER 16 WINTERBERRY COURT HUNT VALLEY, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. 1 Durial /2 Cremation 3 Removal from State 5/3/2008 *4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEM. PARK HILLENDALE. MD of Funeral Service 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Sign tur 8521 LOCH RAVEN BLVD. TOWSON, MD a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List brily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): mmxh disease or condition resulting in death) /Medical **Examiner** mmx41 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 0.0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown ASLUD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital B 25. Was case referred to medical examiner? 1 Yes 2 No 2⊞No 1 Yes To the Hospital or Attanding Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation in by the t 2 Accident Diractor 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funarel Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mo 4/30/05 N31290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 H Charks 70wsa 21204

Registrar DHMH 17 Rev 1/2001

State

Wendy Cloes 2 31. Date filed (Month, Day, Year)

10/0452

MAY 0 2 2008

2. Registrar's Signature

Suite 4202

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Day 2008 Physician 1, 12:59 A.M Anne Gavnor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2/2 F 217-18-3133 86 Director 2/8/1922 Balt., Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Director Baltimore 1☑Yes 2□No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? United States 830 West 40th Street 21211 of America Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2,5 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes XXNo white Specify: <u>م</u> Specify: 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event, In Man Jones. Homemaker Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph William Ketzky Etta Gump ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Gaynor/daughter 206 First Avenue Unit 3A New York, New York 10009 20b. Place of Disposition (Name of cemetery, organization of the place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial

©Cremation 3 ☐ Removal from State Chapel- Bel Air 2008 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee eaceful Aditernatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part I/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BLADDER YEARS Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinitely allocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 KDNo 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2.00No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Physician /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar P.O. Box 68760~ physician the burial aftending p for use as t signed by the a Division of Vital Records, should be peen page 2 s has certificate funeral director, After ours after death.

neral Director: Al
filled in by the fu 24 hours within 24 hou

To the Fune

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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r than "natural", or items 23a or 28a-f sho

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30. Name and address of person who comple

02

2008

29b. Signature and title of certific

(Check only one)

6565 NCHAPLES ST, SUITE-209 DANIEUE POBERMAN, MA 32

and manner stated.

Registrar's Signature

ed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMORE, NO 21204

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		For State Registrar	State of Mar	-	epartment of F Dertificate of a			giene Reg. No. 2008	14390		
Physicia /Medic		1. Decedent's Name (First, Middle, Last) MILDRED	m.		GIORGILL	1	2. Date of Dea Month	th Day Year 30 2008	100 5 () . 14		
Examin		4a. Facility Name (If not institution, give st FRANKLIN Square 5. Social Security Number 6. Sex	HOSPITAL C		Ros	Location of Death			more		
Funeral Director			M 2½ F	ln yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day	1925 W.	thplace (State or Foreign ountry) VIRGINIA		
Maryland a-f show	ctor	10a. State 10b. County MD BALTIM		0c. City, Town o		EDALE	_		10d. Inside City Limits 1 ☐ Yes 2 XNo		
th with the 23a or 28 ist be not	al Director	10e. Street and Number 8901 TALC DRIVE	APT. 1	-D	10f. Zip Code	21237		10g. Citizen of What Co U . S			
Irs a	by Funeral	11. Marital Status 12 Married 2 Married ★ Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2XNo	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Whit			
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tal H d oth	To Be C	17. Father's Name (First, Middle, Last) LUTHER	BARBE			18. Mother's Nam		Maiden Surname) (SMI	TH)		
and 2 shu lealth and m 27 Is m her traum	1	19a. Informant's Name/Relationship (Type JAMES E. BARBE/S	SON	113	ailing Address (Street . 3 RIVERSI	DE ROAD	ESSE	K, MD 2	1221		
permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any Injury or other trau once.	ì	20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funera Frice Licensee	moval from State	20b. Place of Dicemetery, of METRO	sposition (Name of crematory or other place CREMATOR) 22. Name and Address	^{e)} Y 5−1.	-2008	20c. Location - City or CATONSVI EDALE FU			
permi Depa Impo any I		23a. Part1. Enter the disease, or complica	ations that caused the	death Do not	1211 CHE			EDALE, MD	21237		
Physician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Stemic Sue to (or as a co	in Flaw	imatory R	es, onse	0 1		Interval Between Onset and Death 2 - 3 day s		
executed n and al-transit	Social files and the state of t								2 - 30ays		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year							
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e law req has beer je 2 shou	Completed	Diabetes mellitus 24a. Was an autopsy prior to comple									
Iclan: Th	pe	ATrial Flutter, History of GI bleeding performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)									
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he Hospi in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physic 2 ☐ Medical Examine	cian: To the best of m r: On the basis of ex and manner stated	amination_and/o	eath occurred at the tin r investigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manner a late and place, and due	s stated. e to the cause(s)		
To the with Com	A	29b. Signature and title of certifier	Mya S-	Their	29c. License	o number 0 0 5 8 3 7		9d. Date signed (<i>Mont</i>	th, Day, Year)		

3

State

Registrar

Square DR

Baltimore

md 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR MYA S. The IV
31. Date filed (Month, Day, Year)

MAY 0 2 2008

9000 FRANKLIN 32 Registrar's Signature 3

State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Reg. Not. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HARRY S GIMBEL APRIL 27 3:00 P M 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11 SLADE AVENUE, #308 BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 11/07/1911 Birthplace (State or Foreign Country)
 MD 6. Sex. 1 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 220-44-3864 Yrs. 96 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 SLADE AVENUE, #308 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 WHITE Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIAN MEDICAL permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JOSEPH** GIMBEL SARAH P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA GIMBEL / WIFE 11 SLADE AVENUE, #308, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BETH TFILOH 04/29/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Mulle 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tailure Dementiz /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ś þ Division or Vital Record 1 Yes 2 No 3 Probably 4 Honknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XX esidence • Her (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 28,2008 Bultimen MYD 21210-1303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. n. 22. Registrar's Signature Kno W. Like Hue 31. Date filed (Month, Day, Year) MAY 0 2 2008 State Registrar

DHMH 17 Rev 1/2001

Grimple

			For State Registrar	State of Ma	aryland / De _l	partment of				iene	08	43	92			
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Maryland 21215-0036	within and then a	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) Unknown		+) (Gi	cedent's Usual Oc ve kind of work do DO NOT use re	one during mo tired)	ost of working		16b. Kind of	Business/In-	dustry				
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Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		20b. Place of Discometery, co	rematory or other	f place)	5-2-20		20c. Location	•	wn, State Maryla	and			
Balti	permit. Page Depertment Important: If any Injury o		21. Signature of Funeral Service License	PM)	I	22. Name and Action of Puneral I	Home of	f Cator	ling As	hton :	Schwab	Witzk				
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8760,	physician and si the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	907		5 0	N	90 (, 09.	<u></u>			
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Division of	ding Phys .r After this funeral di	atlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Injui (Month, Day	nt 2 ER/Outpat ry 28b. Time (Year)	of 28c. I	niury at Work? 1 Yes 2	286	ne 5 Residence 6 Other (Specify) 8d. Describe how injury occurred							
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	İ		30. Name and address of deson who co	ompleted cause of d	eath (Item 23a) (Typ	e, Print)	lidse	= Rq	16/41	45/5	198	2/04	15			
	Sta Registr		31. Date (Month, Day, Year) MAY 0 2 200	32/Registra	ar's Signature	conti										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Linda Joy Jones 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hanes Hospita ItimoRE CA Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20,1946 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. 1 □ M 2 🙀 F 214-50-4868 62 **Director** Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 77 Camelot Circle 21811 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ ∑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine. once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth E. Winkler ည Merideth C. Page 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Westshire Drive; Baltimore, Maryland 21229
of Disposition (Name of Date 20c. Location - City or Town, State <u>Jennifer L. Jones Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 75 ☐ Other (Specify) Metro Crematory 5/6/2008 4 ☐ Donation Catonsville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign wife Juneral Service Livinsee NO1290 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each fine.

Immediate Cause/Final disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) be executed attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) Division or Vital Records, P.O. 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy perform this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 720 Moster Pella 31. Date filed (Month, Day) 32. Registrar's Signature Year) State MAY 0 2 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 | 4394

		1- For State Registrar				С	ertific	ate of	Deati	7			F	Reg. No.			
Physicia Exami	an/	Decedent's Name (First, Middle,Last)				ise Johnson							2. Date of Death Month April 30, 2008 3. Time of Death 0832 hrs				
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Funeral Director		5. Social Security Nu	mber 35.25	6. Sex	2 X F	7. Age (In yr	s. last bir	thday)	If Unde	er 1 Year Days	If Under 2	24Hrs. Min.	8. Date of B	irth (MM/			Baltinore,
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215-0036 be filed within and Hygiene. The other than	Be Com								Surname)	name) Taskiewicz							
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Baltimore permit. Pages 1: Department of H Important: If it injury or other injury or other		21. Signature of Fund	Other Sa		Tatay	<u> </u>	<u>1018</u>	22. No	ame and	Address of	of Facility artor	n K	Pogla F	BACT	TMORE SIMONE	E M	D2123. CES-Parkville
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S, P.O. uires that th n signed by Id be detach			cant conon	ions co	ontributing t	o death but h	ot resulti	ng in the u	nderiyinç	cause gr	ven in Pari		1 Y	es 2	✓ No 3	Proba	ably 4 Unknown
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Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide	6 Coul	stigation d not be mined		ce of Injury - A		farm, stree	t, factory	, office bu	ilding, etc.	- 1	or Town,	State)			al Route Number, City load, White Marsh,
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	Σ	29b. Signature and ti	tle of certifie		5				29	O.C.N					. Date signed by 1, 2008		th, Day, Year)
10		30. Name and addres				se of death (I			t, Balti	more, N	/ID 2120)1					
S	ate	31. Date filed (Month	Day Year)	2 20	08 32. R	oistrar's Sigi	nature	40	outh	,							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Jeffrey 57aM Jennings 05 /Medical Oi 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Iniversity Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 12, 1981 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 2 F Months Days Hours Salisbury, MD. 220-25-7536 Director 27 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Berlin Worchester Co. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 11647 Beauchamp Road 21811 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chef Catering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Ellen Moulton Armand Shelby Hall 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Berlin, Maryland Margaret Ellen Jennings (Mother) 11647 Beauchamp Road 21811 20b. Place of Disposition (Name of cemetery crematory or other place) Pate 7 2008 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its any Injury or o May 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Peaceful Alternatives Funeral&Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 2 23a. Parfil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** days Cohol resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed Due to (or as a consequence of): physician Physician/Medical attending physical for use as the b 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Tancreatiti 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a Was an page 2 autopsy certificate 1 Yes 2 □ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident death after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Division or Vital Records, P.O. Box 68760, e Funeral! completely To the I within 2.

> State Registrar

29b. Signature and title of certifier

DRIENNE

31. Date filed (Month, Day, Year)

Lenne

MAY 0 2 2008

DHMH 17 Rev 1/2001

5.

22

. Registrar's Signature

and manner stated.

lowers

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene

29c. License number

Baltimore

21201

Stanley Johnson 08-03069

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK	State of Maryland / D 1- For State Registrar	epartment of <i>Certificate of</i>		lygiene _{Reg}	.No. 200	8 1439					
Physician/	Decedent's Name (First, Middle,Last)			Date of Death Month	Day Year	3. Time of Death 0330 hrs					
Medical Examiner	Stanley Leon 4a. Facility Name (if not institution, give street and number)		Ohnson 4b. City, Town, or Location of Deat	April 20, 20	08 4c. County of Death						
	University of Maryland Hospital		Baltimore								
Funeral Director		yrs. last birthday) 25 yrs	If Under 1 Year If Under 24Hi Months Days Hours Mi		(MM/DD/YYYY) 9. Bir 82 Foreig 2/82	thplace (State or gn ountry) KS					
	Usual Residence of Decedent			1 11/ 11		10d. Inside City Limits					
w an	10a. State	City, Town or Locati Rei		1 Yes							
Aaryland 28s-f show any <u>1.st once.</u> ector	10e. Street and Number		10f. Zip Code	100	10g. Citizen of What Country?						
the Maryland a or 28a-f sh fiffied at once	16 Chestnut Hill Lane W	est	21136		U.S.A.						
t with the mas 23s be not eral	11. Mantal Status 12. Was Decedent Eve	er in U.S. 13. Wa	I is Decedent of Hispanic Origin? (\$ 'es, specify Cuban, Mexican, Puerl		14. Race - Amer White, etc.	ican Indian, Black,					
r death with or items 23 must be no	1 Yes 2 X	No		o rican, etc.)		Black					
ural", miner	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)		Yes 2 No specify: nt's Usual Occupation (Give kind of	work done	Specify: 16b. Kind of Business/						
72 hou "nat al Exa	Elementary/Secondary (0-12) College (1-4 or 5+)	during m	ost of working life. DO NOT use re								
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan Completed	12th grade na	Un	employed		Unemployed						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	,						
212 tould be d Ment is mark tic ever	Stanley Johnson Sr. 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street and Number of hestnut Hill	le Broc Rural Route Numb	per, City or Town, State	e, Zip Code)					
MD id 2 shulth and ulth and m 27 is aumat	Michelle Powell-Mother										
Ore, es 1 ar of Hez of Hez If itel	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	crematory or ot			20c. Location - City of						
timent rtment rtment rtment y or ol	4. Donation 5 Other Specify: 2 . Sunature of Funeral Servi¢e Licenşee/			25/08	Baltimor	e Co, Md					
Bal Permi Depa Impo	Dura D. Refe	Ma	Name and Address of Facility rch F/H West	. Balti	more. Md	21215					
Physician	14300 Wabash Ave, Baltimore, Md 21215 23a; Part I. Ebi, r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervent failure. List only one cause on each line.										
/Medical xaminer	Immediate Cause (Final disease a Multiple Gunshot Wounds										
*	b 200 to 101 00 0 00 100 400	ence of):									
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ence of):									
fed Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	ence of):				+					
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50, te be execute ysician and burial - tra	UNPENDED X AMENDED Item#8	,perFH,C879,	5/2/08,WS		Lood Data of dally	J					
8876 rtificat ing phy as the											
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O. Box 6876 that the death certificate ned by the attending phetached for use as the by Physician/IV	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to t										
Records, P.(The law requires tha ficate has been signed to spage 2 should be det. Completed by				1 Yes	2 ✔ No 3 Pro	bably 4 Unknown					
ords w requi is been should				24a. Was a autops	y prior to	utopsy findings available completion of cause of					
tal Recol				perform 1 Yes 2		es 2 No					
ician: certifi rector,	25. Was case referred to medical examiner?		26.Place of Death (Chec								
Division of Vital Records, spital or Attending Physician: The law requirents after death. reral Director: After this certificate has been a filled in by the funeral director, page 2 should Certification: To Be Complete	1 Yes 2 No	2 ER/Outpatient		28d. Describe h	Residence 6 Other Owinjury occurred	er:					
Division o ital or Attending ars after death. ral Director: Aft lled in by the func ertification:	27. Manner of Death 1 Natural 5 Pending Province Apr 20, 2008	FOUND: 0300 hrs	1 Yes 2 ✔ No	Subject shot							
ivisi or Att after de Direct I in by	29a Plans of Injury	At home form etro	et, factory, office building, etc.			ural Route Number, City					
Di ospital hours a meral y filled	100- 0-400-		in front Yard of Rowhouse	1	ate) it South, Baltimore,						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	one) 2 Medical Examiner: On the basis of examina	nowledge, death occu ation and/or investiga	rred at the time, date and place, a tion, in my opinion, death occurred	ng due to the cause d at the time, date a	e(s) and manner as sta and place, and due to t	neo. he cause(s)					
To roor	29b. Signature and title of certifier		29c. License number		29d. Date signed (Me	onth, Day,Year)					
	hy hi, not		O.C.M.E.		April 20, 2008						
2	30. Name and address of person who completed cause of death Ling Li, MD Assistant Medical Examiner		et, Baltimore, MD 21201								
State	31. Date filed (Month, Day, Year) 32. Red Strar's S	Signature	and a								
Registra	MAY 0 5 2008 Magazine	1 KS /15									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day April 30, 2008 Everett Jackson Jenkins, Jr. 9:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner 6371 Lawyers Hill Road Elkridge Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-21-1924 Birthplace (State or Foreign Country) Funeral Months Days Hours Min. XXM 2□ F 219-12-6574 84 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2XXNo MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6371 Lawvers Hill Road 21075 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify <u>۾</u> Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Everett Jackson Jenkins Lena Halsev ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ona Lee Jenkins - wife 6371 Lawyers Hill Road, Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Piney Creek, NC Pinev Creek Meth. Cem. 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OST disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

be executed burial-tran P.O. Box 68760 physician the attending pl ned by the a detached f signed to Division of Vital Records, page 2 should peen has director, this funeral (After

Director

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th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Actical Examinatings to notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Health a

Department of Health Important: If item 27 any injury or other tronge.

Physician

/Medical

Examiner

Maryland 21215-0036

Baltimore,

To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After filled in by the completely

State

Dr. Clement B. Knight, 31. Date filed (Month, Day, Year) MAY 0 2 2008

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 11065 Little Patuxent Pkwy., Columbia, 32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD 21044

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** April 25, 12:25 A M Louise Mildred Johnson 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges 16305 Gales Court Laure 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🐼 F Vrs Director 100-24-0727 86 Oct. 23, 1921 New Jersey Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Madical Examinat must be notified. 1 ☐ Yes 2 ☑ No Director Maryland Prince Georges Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 16305 Gales Court 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ۵ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Ado1ph Hoffman Mildred Hoffman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Johnson- husband 16305 Gales Court, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4/25/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Savia Licensee 22. Name and Address of Facility Fleck Funeral Home, INC. 7601 Sandy Spring Rd., Laurel, MD 20707 MO1234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Severe Advanced Osteoporosis 10 years /Medical Due to (or as a consequence of) Examiner Multiple Pathological Fractures 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Dementia the attending physician and hed for use as the burial-tran 2 years Due to (or as a consequence of) P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ pe 2 No 1 🗆 Yes 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform this certificate 1 □Yes 2 □ 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 Natural 5 ☐ Pending investigation To the ricer...
within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D13671 April 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 B.G. Manejwala, M.D. 1#201 Laurel Park Drive, Laurel, MD 20707 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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	_	1 - For State Registrar					rtificate of		Re	g. No. 🤈 🎧	08	14399
Physicia /Medica	al	1. Decedent's Name (Fin	Ster	rling	Kent	Jr.	14.07.	- A - A - A - A - A - A - A - A - A - A	2. Date of Death Month May	Day 01	2008	3. Time of Death 5:15 P M
Examine	er	4a. Facility Name (If not in 200 Lower						erna Park		4c. County	ne Arı	undel
Funeral Director		5. Social Security Number 265–26–2193		.Sex 1⊠M 2□F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 29	^{Year)} 1925	9. Birthpi Count	ace (State or Foreign ry)
Maryland I-f show fled at	tor		County	Arundel	10c. Ci	ty, Town or L		erna Park			10	od. Inside City Limits 1 ☐ Yes 2 No
with the	Director	10e. Street and Number 200 Lower	Mago	thy Reac	h Poad		10f. Zip Code	21146	10	g. Citizen of	What Count	ry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ē	11. Marital Status 1 ☐ Never Married	2 Married	12. Was Dec	cedent Ever in U orces? 2 ☐ No	.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	ce - America ck, White, e	etc.
in 72 hours "natural", Medical Exa	Completed by	(Specify or	Decedent's ly highest	Year or I Education grade completed	Dates:	16a. Dece (Give life.	dent's Usual Occu		ng 1	6b. Kind of B		
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ould be file I Mental H narked oth	To Be		Sterl	ing Ke	nt Sr			18. Mother's Name Peggy	Hat	ch		
aith and 2 sh aith and 27 Is m or traum		19a. Informant's Name/F		, ,	ouse)			and Number or Rura				_{Code)} rk, MD 2114
Pages 1 a nent of Her nt: If Item		20a. Method of Disposition 1 X Burial 2 Cre 4 Donation 5	mation 3	☐Removal from	20b. I	Place of Disponentery, cre	osition (Name of matory or other pla 11 Cemete	ce) May	ate 2	0c. Location	- City or Tov	
permit. Departm Importal any Inju		21. Signatule of Funeral	-			2	2. Name and Addre		tallings			
Physician /Medical Examiner e private transit	Examiner	23a. Part1. Enter the disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a	(or as a consec	EST/1 quence of): M/C quence of):	18 HE	ng, such as cardiac o	LURE			Approximate Interval Between Onset and Death
but but	hysician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 □ Yes 2 □ No 9 □ Unknown	hs?	1 ☐Live 4 ☐ Preg 9 ☐ Unkr		al déath 3[death 5[□Ectopic pregnanc □ Other (specify) _				ate of deliver	y Day Year
uires tha	d by	Part II. Other significant						ven in Part I. DISEASE				e cause of death?
The law requate has been age 2 shoul	Completed by	SLEEF							24a. Was an autopsy perform	ed?		osy findings available apletion of cause of
iclan: certifica ector, p	Be	25. Was case referred to examiner?	medical	Hospital:	·		ot 3E DOA Oth	26. Place of Death	(Check only one)		
r Attending Phys or death. rector: After this by the funeral di	Certification: To	2 Accident	Pending investigat Could not determine	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	of 28c. Inju	y at rk? Yes 2 □ No	ne 5 A Resider 28d. Describe hov 28f. Location (Stree City or Town,	v injury occur	rred	
e Hospital o 24 hours aft e Funeral Di etely filled in	Medical Cer	29a. Certifier 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	Certifying Medical Ex	Physician: To the laminer: On the l	e best of my kno	owledge, deat	th occurred at the ti	ime, date and place, a	and due to the car	use(s) and m	anner as sta	ated. the cause(s)
To the within To the compl	Me	29b. Signature and title of		13 Kin			29c. Licens	54574		d. Date signe		Day, Year) 2008
6		30. Name and address o	MD	no completed cau	se of death (Iter	n 23a) (Type,	Print) n Hur 6A	t Glen	BURNIE	- m	po	21061
Stat Registra	e	31. Date filed (Marth D	" O°Z 2	2008	Registrar's Signa	A A	ark)	4 Glen				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician P^{M} 04-28-2008 Dennis A. Killian 2002 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Hospital Bel Air Harford 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ▼ M 2 □ F Director 215-58-0955 10-07-1952 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or e items 23a 1905 Stockton Rd Funeral 21085 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 No If Yes, GiveXX Year or Dates: "natural", or 1 ☐ Yes 2X No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) n and Mental Hygiene. College (1-4or 5+) 10 Burner Service Tech. Heating and Air Cond. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Bernard Killian Deloris Luckhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margie R. Killian (Wife) 1905 Stockton Rd Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important; If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 05-03-2008 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician IHPOL PENSION LONG SAMBING /Medical Due to (or as a consequence of): Examiner KEND FAILURE LONG STANDING Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner LONG SMMOING DIMOCREZ MULINSI Due to (or as a consequence of): physician s the burial MouBID 0951N LONG STANDING Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HPALLIPIOMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed SHADNIC VENOUS INSUPPICIONCY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an OBSMULTUE death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 KER/Outpatient 3 □ DOA filled in by the fune al 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natura! 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Kiliagh Cynn Becords, P.S. Box 8750 within 24 hours a

To the Funeral [

12

Registrar

соmpletely

CREGORY M 31. Date filed (Month, Day, Year) MAY 05

29b. Signature and the of certifier

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dottmeren

and manner stated.

Mil Stand

2227 OLD 32 Registrar's Signature

29d. Date signed (Month, Day, Year)

EMMORRON PO SUITE 220 BEL MR MD

ORIGINAL

29c. License number

H 40769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:30 8 **Physician** APRIL 2008 EDWARD JOSEPH KELLEY SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE 7926 OAKDALE AVE ROSEDALE 8. Date of Birth 9. Birthplace (State or Formal Month, Day, Year) 9. VIRGINIA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1**X** M 2□ F 214 64 6380 Director Usual Besidence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕍 No Director MD BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7926 OAKDALE AVENUE 21237 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examines and. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 2 WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRACTOR REPAIRS CONSTRUCTION 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEO C. KELLEY DOLORES STAHL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KYLE ROAD GRANITEVILLE, JOSEPH E. KELLEY Jr./Son 29829 133 SC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 5/1/08 Metro Crematory BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of): 5 years **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the attending ph for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 3 Probably 4 □Unknown 1□ Yes 2□ No. Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe certificate 2 **2** No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 24 hours after death. • Funeral Director: • Setely filled in by the fi death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

Campbell 31. Date filed (Month, Day, 2008 MAY 02

29b. Signature and title of certifier

30. Name and address of person who completed of

Boulevard 32. Registrar's Signature

e of death (Item 23a) (Type, Print)

Marsh, MID

29c. License number

000 36343

29d. Date signed (Month, Day, Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jacob Kennedy, Jr. State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death									
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) 1. Tarob Kennedy Tr Month Day Year								
ď.	4a. Facility Name (if not institution, give street and number) University Hospital April 25, 2008 4b. City, Town, or Location of Death Baltimore								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of State of Birth (MM/DD/YYYY) 19. Birthplace (State of Birth (MM/DD/YYY) 19. Birthplace (State of Birth (MM/DD/YYYY) 19. Birthplace (State of Birth (MM/DD/YYYY) 19. Birthplace (MM/DD/YYYY) 19. Birthplace (MM/DD/YYYY) 19. Birth	or MD							
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Cit	tv Limits							
È .	MD Baltimore Baltimore	-							
the Maryland ha or 28a-f sho biffed at once.	10e. Street and Number 2910 Vermont Avenue 10f. Zip Code 21227 10g. Citizen of What Country? USA								
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Blan White, etc.	ck,							
ours after atural", aminer	3 Wildowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 244 No specify: Specify: White	e							
5-0036 led within 72 hour Hygiene, other than "natu the Medic-I Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Operator Manufacturing Manufacturing								
1215-0 be filed wental Hygic went, the Merch Color.	Jacob Kennedy, Sr. Delores Harlow								
MD 21 d 2 should 1 tht and Mer n 27 is mar umatic ev	19a. Informant's Name/Relationship (Type, Print) Carol A. Kennedy / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2910 Vermont Avenue, Baltimore MD 21227								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medic-I Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition 1								
Baltil permit. Departm Importa	21. Signature of Funeral Service Licensee Victor Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, BAltimore MD 21230								
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries Approximate Between Or Deat	nset and							
xaminer	or condition resulting in death) Due to (or as a consequence of):								
ted Annist	Sequentially list conditions,								
executed an and al- transit ical Exar									
be es urial urial									
Records, P.O. Box 68760 The law requires that the death certificate I cate has been signed by the attending physyage 2 should be detached for use as the brompleted by Physician/Me	1 Yes 2 No 9 Unknown 2 Other (Specify)	⁄ear							
P.O. Bo sthat the de gned by the e detached f by Phy		eath?							
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by Mineral director, page 2 should be detact on: To Be Completed by P.		available							
of Vital Records, ag Physician: The law requir ther this certificate has been si neral director, page 2 should b. 1: To Be Completec		_							
Vital ysician: ysician: director o Be	25. Was case referred to medical examiner? 1 Ves 2 No 1 No								
	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	xed							
Division of Hospital or Attending 24 hours after death. Puneral Director: Alguedy filled in by the function and Certification.	2 Accident Investigation 3 Suicide 6 Could not be determined Specify Local Street A Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 2700 block Annapolis Road, Baltimore, MD	ber, City							
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Me We		-							
Q _j	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State Registrar	31. Date filed (Month), Dally Ver) 2008 Section Signaline								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIPM/20b, c. perFH, 68/9,5/9/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Year Ami 3 4:40 AM /Medical 0 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sinai Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Olvemi **Funeral** 1 M 2 M F Months 9 220-01-4232 Director irainia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 Yes 2 No Funeral Director More 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with man 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status is of Health and Mental Hygiene.
If item 27 is marked other than "natural", or item or other traumatic event, the Medical Examiner. 1 Never Married 2 Married arvland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 □ Divorced ac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental ! ant: If item 27 Is marked o 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

1 210n 5/ Ms. Margurite Ave 2121 20a. Method of Disposition Date 20c. Location - City or Town, State 16/2008 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lansdowne Important: It any injury o Dundal 21. Signature of Funeral Service Licensee Joseph L. Ryss Fur 2222 W. North Ave. Funeral 1. Home, P.A. Q 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pulmonary Fi 600 848 disease or condition resulting in death) inknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of): Sox 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □ Ectopic pregnancy Month Day Year 5 Other (specify) this certificate has been signed by the arral director, page 2 should be detached it 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Poreas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28h. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pendle Harithe MD 065718 30,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENDLI, MD,

33 Registrar's Signature HOSPITAL BALTIMORE SINAI HARITHA 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Byron Ervin Love11 26. 2008 /Medical April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □XM 2 □ F Months Director 002-32-0004 63 Aug 21, 1944 Connecticut Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dcal Examiner must be notified at 1 □Yes 2 KINO Director Maryland | Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 486 Bruce Avenue Funeral 21113 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Computer Specialist National Security Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Rodney Lincoln Love11 Helen Bernice Livingston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Lovell/wife 486 Bruce Avenue Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 Donation 5 Dother (Specify) West Arundel Crematory 4/29/2008 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee uanity R 4 Amor 1411 Annapolis Road Odenton, Maryland 21113 23a. Parti Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ovam negation Septicime a
Due to (or as a consequence of): Unknows /Medical **Examiner** Renal tailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician ar s the burial-to Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Mo-bid obesity 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an After this certificate has funeral director, page 2 s autopsy performed?

1 Yes 2 X No 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D 9801 Georgia Ave suit 3-32 Silverspring MD 20902 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

ROINTAN FARAHIFAR

MAY 0 5 2008

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear **Physician** Month LUBERESKIF 09:10 AM APRIL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4908 EAST FEDERAL STREET BALTIMORE N/A8. Date of Birth (Month, Day, Year) 2 / 09 / 1914 Social Security Number 6. Sex Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M **X**7F 94 PENNSYLVANIA Yrs. 166 20 1096 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director MD N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? 4908 EAST FEDERAL STREET 21205 USA Funeral filed within 72 hours after death 12, Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced WHITE Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. HOMEMAKER OWN HOME 0 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN F. KLICK ပ MARY UHRIH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 19a. Informant's Name/Relationship (Type. Print) ANTHONY J. LUBERESKIE/HUSBAND tem 27 4908 EAST FEDERAL STREET BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 Donation 5 Other (Specify) ENIONEMENT GARDENS OF FAITH BALTIMORE, MD 5/3/08 21. Signature of Funer | Service | icensee 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME any 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ACIDEMIA WEEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-t Due to (or as a consequence of) Box 68760, attending physician for use as the buria certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached the 9☐Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by DEMENTIA DIARRHE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? page certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: completely filled in by the f To the

5

DHMH 17 Rev 1/2001

State Registrar

2022 JENNIFER 31. Date filed (Month, Day, Year) MAY 0 2

29b. Signature and title of certifier

HOPKINS 32. Registrar's Signature A SHOWN

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

062032

BAYVIEW CIRCLE BALTIMORE

29d. Date signed (Month, Day, Year)

MR1130

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year E'9, E'008 **Physician** AFRIL 6:15A EVELYN LEVIN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Saint Joseph Medical Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🗙 F 212-18-5079 Director 88 02/08/1920 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1550 BEDFORD ROAD, #317 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES SHOE STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JOSEPH** LANDSMAN ROSE 2 BELKOWITZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTIN LEVIN / SON 3633 GLENGYLE AVENUE, #F-5, BALTIMORE, 21215 20b. Place of Disposition (Name of cemeter) cramatory of others
BETH ISRAEL 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 05/01/2008 BALTIMORE, MD 22. Name and Address of Facility neral Service Lice SOL LEVINSON & BROS., INC. 8900_REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC NON-SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner and resulting in death) Last Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. aftending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an has autopsy 1∐ Yes 2 **N**O 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 2 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Hospital or Attending 24 hours after death. 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 08 22 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE. TOWSON, MARYLAND BOON FOR LIM Begistrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Mor 30 AM /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tella 0 Spice timore Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Days Hours Min Year. 168-18-3880 Wilkes Barre PA Director 86 ept 18, 192 Usual Residence of Decedent death with the Maryland 10b. County 10a. State s 23a or 28a-f show ust be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Itimore 10e. Street and Number 10g. Citizen of What Country? 21234 Funeral Race - American Indian, Black, White, etc. T is marked other than "natural", or items traumatic event, the Medical Evantine in 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 1 No þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 cretari Medica 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 lartin Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Howard Morrison 2915 Hadora Court #D Baltimore MD 21234 Injury or other Department of Heal Important: If item 2 any injury or other once. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Finanal Chapter to Cremation Services - Behin 5/3/2008 Forest Hill, Maryland 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel + Cremation Services-Parkville 21. Signature of Funeral Service Licensee Parkville MD 8800 Harford Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin attending physician and for use as the huring resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 📉 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a d be detached for 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a. Was an autopsy performed this certificate Vital 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 👿 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HOSPICE ot After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation Injury death. filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State MAY 0 2 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8, perFH,035 at 5/5/War Fland / Department of Health and Mental Hygiene amend #26 Per Phy C879 5/02/08 JMC ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8⁵²p Month **Physician** 04 30 2008 Gloria J. Moore /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House/Montgomery Hospice Montgomery Rockville If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth 9/27/081942 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1□M 2√F MA 032-30-1098 65 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Rockville permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2 No MD Montgomery Director 10e Street and Number 10g. Citizen of What Country? 5912 Bethlehem Court 20855 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Airican 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 💥 ☐ No Specify: Specify: American 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DeathCare Ind. Elementary/Secondary (0-12) College (1-4or 5+) Funeral Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther Mitchell Geneva Mitchell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5912 Bethleham Court, Rockville, MD 20855 Sandra Fraser/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/2/08 Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHari P. Close F.Svs, p.A. 5126 Belair Rd, Balt., MD 21205-5105 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter 6 e d sea shock, or heart frilure sease, or compet ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Metastatic Cancer of Lung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nding physician and use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Metastatic Breast Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Telephone (Specify) Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 XNo 2 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending hin 24 hours after death. Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral [Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check one) 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) 5/1/08 D0064615

Registrar

Wroblewski, MD 6001 Muncaster Mill Rd, Rockville, MD 20851

and address of person who completed cause of death (Item 23a) (Type, Print)

💏 gistrar's Signature

WELL !

Geneviene
31. Date filed (Month, Day, Year)

MAY 0 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Keira Gwenise Mosaid

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nore, MD 21215-0036 sages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural", other traumafic event, the Medical Examiner.		Lachelle Mosaid 20a. Method of Disposition	Mother	1652 Place of Disposit	Fendall	Court	Croiton,	Maryland 20c. Location - City	
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Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	١,	21 Signature of Funeral Service Lice	/1. // 1		onaldson	n Funera	1 Home &	Crematory	y, P.A.
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760, cate be executed physician and he burial - transit		d							
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Vital Records, sysician: The law require this certificate has been si director, page 2 should b	Completed							rmed? deati 2 ✓ No 1	Yes 2 No
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1 Of ling Pt After funeral	١	27. Manner of Death 1 Natural 5 Deading	28a. Date of Injury FOUND:	28b. Time of In FOUND:		jury at Work?		how injury occurred auto fixed objec	t collision
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Division tal or Attendii sa after death.	Certification:	3 Suicide 6 Could no			t, factory, office	building, etc.		Street and Number of State) ell Branch Road, D	r Rural Route Number, City
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending competedy filled in by the funeral director, page 2 should be detached for use as:		29a. Certifier	(Opcomy) Iviajor (Coa		and at the time	data and sizes	1		
To the H within 24 To the F complete	Medical		cian: To the best of my knowleder:On the basis of examination a						
To To COUR	Mec	29b Signature and title of certifier	and manner stated.			nse number		29d. Date signed	
		/ / ilos les	1110		0.0	M.E.		April 20, 2008	
0		30. Name and address of person who	completed cause of death (Item	n 23a)					
7		· · ·	stant Medical Examiner	•	Street, Balt	imore, MD 2	1201		
		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure Apa	we				
Regis	VIII.	NANY 0 5 2	11111 1 11 11 11 11 11 11 11 11 11 11 1	A.C. ACCEPT					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last)

Physic /Med Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medica Examine

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ine	•	4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location of	f Death	,	40	c. County of Dea	th	
IIIe	_	The Johns Hopkins Hospital		Baltin	more	City						
		5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthda	y) If Under		If Under : Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Julu 15	th ly, Year) 193		thplace (State ountry)	or Foreign
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	I Director	10e. Street and Number 508 N. Pulaski Street		10f. Zip	-Code	21223			10g. C	itizen of What Co USA		
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	o Be	Murl Coplin, Sr.					Lo	ouise C.	King	3		
		19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address	s (Street	and Numbe	er or Rura	al Route Numb	er, City	or Town, State,	Zip Code)	
		Karen Macer McDonald / Daughter	2809	Mount 1	Ho11y	Street	t; Bal	ltimore,	Mary	land 212	16	
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	au/	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐		3 🗌 Ectopic p	oregnanc	v				23d. Date of de	-	Year
	ysician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time		5 Other (st		,				Month	Day	real
	F S	9 Unknown / 9 Unknown / Part II. Other significant conditions contributing to death but no	at reculting in t	ha undarlvina	cause di	ven in Part	1	23a Did	tobacco	use contribute	to the cause of	death?
	Completed by	Charles significant conditions contributing to death out the	(- le	Ten	oddoc gi	von in ran	1,	1 🗆		2 No 3 F	_	Unknown
	sted	- Chiene (91) proces	C /E6	16600	1-4			04= 10/00				available
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	Be	25. Was case referred to medical examiner? Hospital:			Oth	071		(Check only o				
	၉	1 Ly inpatient	2 ER/Outpa		JA	4 🗆 NU	- 1			6 Other (Spe	ecify)	
	Certification:	27. Manner of Death 1 ★Natural 5 Pending (Month, Day Year 2 △ Accident investigation	r) 28b. Tim Inju	iry M	28¢. Injur Worl 1 □	yat k? Yes 2 ⊟		28d. Describe	now inj	ury occurred		
	ica	3 ☐ Suicide 6 ☐ Could not be 28e Place of injury	At home, farm,	, street, factor						and Number or I	Rural Route Nu	mber,
	E	4 ☐ Homicide determined building, etc. (Sp.	pecify)					City or To	wn, Stai	te)		
	Medical (29a. Certifier (check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	/ knowledge, d mination and/c	eath occurred or investigation	at the tir	me, date an opinion, dea	nd place, ath occur	and due to the red at the time	e cause e, date a	(s) and manner a and place, and d	as stated. ue to the cause	o(s)
	₩ B	29b. Signature and title of certifier		290	c. Licens	e number .			29d. E	ate signed (Mon	th, Day, Year)	
		Sant O- 1	M.D.		RES	5-0	00		Apr	./ 29	, 200	8
		30. Name and address of person who completed cause of death	n (Item 23a) (Ty	pe, Print)						o		04605
		Santosh Commen	21	49			600 N	North W	oite	St, Baltim	ore, MD,	21287
Stat stra		31. Date filed (Month, Day, Year) MAY 0 5 2008	signature	barket.								
_		111111	7.3									

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARTHA ANN MESSENGER Year 6:55A 2008 April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) Aug. 31, 1941 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕶 F Months Days Hours Min Country) 218~36~8965 66 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√CXNo Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 322 Royal Oak Drive 21015 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>12th grade</u> N/A Medical Clerk Pediatricians Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde Ray Sills Mittie Blown McCloud 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 322 Royal Oak Drive Bel Air, Md. 21015 Joseph L. Messenger, Sr. 20a. Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill M. G. 5-3-2008 Baltimore, Md. 21. Signature of Funeral Service Licensee ^{22.} Name and Address of Facility Lassahn Funeral 7401 Belair Rd. Lasahn Home Baltimore, Maryland J. 3. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LEUSY month disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 2 E-No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) No Spus 1∐ Yes 21☑No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examiner

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is many injury or other traum

Pages nent of I

Physician

/Medical

Examiner

Director

Completed by Funeral

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Funeral

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ed other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at

2 should be filed within 72 hours after death v and Mental Hygiene. Is marked other than "natural", or Items 23s

Baltimore, Maryland 21215-0036

the Hospital or Attending Physlcian: The law requires that the death certificate be executed 15 burial attending physician for use as the buria the ģ signed I page 2 s

Physician/Medical

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Completed

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Medical Certification: To

Box 68760.

P.0.

Division of Vital Records,

certificate this After 24 hours after death. Funeral Director: A filled in by

10

within 24

completely

31. Date filed (Month, Day, Year) State

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifie

determined

The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles st, Tows W NO 21204 M 6701

5 2008

and manner stated

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April Day 30 **Physician** Louise E. Milchling 2008 8:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1517 Shore Road 8. Date of Birth (Month, Day, Year) Middle River Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M M F 218-22-2938 78 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notiffed at MD Baltimore 1 ☐ Yes 2 ☑ No Director Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9563 Devonwood Road 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank A. Knauff Helen Harvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Shore Road Baltimore MD 21220 Patricia Blondell/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of He Important: If iten any Injury or oth 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 5/5/08 Baltimore MD 4 Donation 5 Dother (Specify) Balto. Mb 21. Signature of Funeral Service Licens 22. Name and Address of Facility 300 Mace Ave. Connelly Funeral Home of Essex mplications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final CONGESTIVE NEADT FAILURE disease or condition resulting in death) Due to (or as a consequence of): MITRAL INSUFFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1□ Yes 2☑No 26. Place of Death (Check only one)

Physician /Medical Examiner

be execute

the death certificate

P.O. Box 68760

Division or Vital Records,

2 should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or Items 23a or

of Health item 27

Saltimore, Maryland 21215-0036

use as the burial-tran attending physician for use as the burial signed by the a certificate has been si rector, page 2 should funeral director, Be ို After this Certification: spital or Attendl nours after death. neral Director; A filled in by the fu

29a. Certifier (Check only

25. Was case referre examiner? 1 ☐ Yes 2 ☐ N	
27. Manner of Death	
1 Natural	5 Pending

investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

MO

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 5.5 Te 1 he 45 28c. Injury at Work? 1 TYes 2 TNo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7602 Belay Rd. Balto MD 21236 3. Registrar's Signature

Registrar

State

within 24 hours at To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Apail Day **Physician** 5:40 P M 9€ 4008 Eugene Stephen Myer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1XIM 2□ F 06-20-1938 Maryland 69 Director 212-36-0654 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County ty⊒Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or dical Examiner must be 1 West Conway Street, Apt. 703 21201 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Tractor Trailer Driver Freight Company 77 Is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be finance and Mental H Be Nicholas Nelson Myer Julia Eva Bush P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 Elizabeth S. Collins - Sister 1 West Conway Street, #703, Baltimore, MD 21201 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If Iter
any injury or oth April 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 29, 2008 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland Metro crematory 21. Signature of Funeral Service Licensee MOO053 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Mark H. Broken MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** corrlac amy thomia 30 MINUDS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerone hear alseome 10475 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner 20 415 Hyportonslan physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): mollitus 11 Dichdes Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ in the past 12 months? Month Year 4☐Pregnant at time of death ☐ Yes 2☐ No 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Chance chestuckte Lung disease 1 Tyes 2 No 3 Probably 4 Munknown Completed Recourement MUEL MANA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 s has autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 pr Yes 2 □ No 2 ER/Outpatient 3 DOA မ 1 Inpatient After this funeral of 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

certificate be executed Box 68760,23 Ö σ. Records, or Vital

Division or Attending

death.

Hospital

within 24 hours a er death To the Funeral Director: completely filled in by the

Baltimore, Maryland 21215-0036

Medical Certification: 1 Natural 2 Accident 3 ☐ Suicide

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifie

4 Homicide

29a. Certifier

29c. License number D36494

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 4128108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 216 maidentheire loine calensville mis

K DESAL MD 31. Date filed (Month, Day, Year) MAY 0 2 2008

32. Registrar's Signature

and manner stated.



State

Registrar

	Phy /N Ex	/s le an
Division or Vital Records, P.O. Box 68760,	pital or Attending Physician: The law requires that the death certificate be executed	ours after death.

		nt in Black Indelible Ink. Ensure A aryland / Department of Health and N Certificate of Death	•							
nysician Medical	1. Decedent's Name (First, Middle, Last) GERTRUDE	MAINEN	2. Date of Death Day Year 3. Time of Death A Month Day 2008 12: 44pm							
xaminer neral	404 00	4b. City, Town, or Location of Death A LTIM OF le (In yrs. last birthday) Yrs. 4b. City, Town, or Location of Death A LTIM OF Months Days Hours Min.	4c. County of Death N/A 8. Date of Birth (Month, Day, Year) 08/15/1912 4c. County of Death N/A 9. Birthplace (State or Foreign Country) RUSSIA							
fled at tor	10a. State 10b. County MD N/A	10c. City, Town or Location BALTIMORE	10d. Inside City Limits 1 🛣 Yes 2 □ No							
Funeral Director	10e. Street and Number 2711 JENNER DRIVE	10f. Zip Code 21209	10g. Citizen of What Country? USA							
Examiner m by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	If Yes, specity Cuban, Mexican, Puerto	pecify Yes or No- Dican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE							
t, the Medical Exan	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or to the control of	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) HOMEMAKER	16b. Kind of Business/Industry OWN HOME							
atic event, the To Be Co	17. Father's Name (<i>First, Middle, Last</i>) MORRIS		NECHAMA SHAPIRO							
ther trauma	19a. Informant's Name/Relationship (Type. Print) HANNAH MILLER / DAUGHTER 20a. Method of Disposition	19b. Mailing Address (Street and Number or Rule 1204 WOODLAND ROAL 20b. Place of Disposition (Name of	Tall Route Number, City or Town, State, Zip Code							
any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Description of Disposition 1 Description 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	NER TAMID 22. Name and Address of Facility OL	1/2008 ROSEDALE, MD LEVINSON & BROS., INC. DAD - PIKESVILLE, MD 21208							
s the burial-transit and leading to the burial-transit and leading to the burial transit and leading transit and lea	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
for use as		e pf pregnancy 2	23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death be CMS my words cylindric	out not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow							
completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	25. Was ase referred to medical examiner? 1	ent 2 ER/Outpatient 3 DOA Other: 4 Nursing H	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N							
pletely filled edical C		of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occutated.								
Me	30. Name and address of person who completed cause of SPAS KOTEV, MD, Single	29c. License number M. D. RES 001 death (Item 23a) (Type, Print) HDC 07TAL 0F BALTIM 06	29d. Date signed (Month, Day, Year) APRIL 28, 2006 2E, 2401W. Belvedese Ave, MD							
State egistrar	31. Date filed (Month, Day, Year) MAY 0 2 2008	rar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:00a. M Nicholson 04 28 2008 Helen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Joseph Richey Hospice 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M **X**□ F 12 06 220-30-6504 Director 73 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 1XYes 2 No 28a-f sh MD NA Baltimore Director death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a or U.S.A. 21230 600 Light Street Apt 630 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Iten ury or other traumafte event, the Medical Examinet ury or other traumafte event, the Medical Examinet 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: Black ٥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Household Technician 4th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Rebecca Nicholson George Sawyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau 2118 Mt. Holly Street, Baltimore, Md 21216 Deloris Walters-Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ♥ Burial 2 Cremation 3 Removal from State Mt. Zion Baltimore, Md 5/3/08 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md ala 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due lo (or a d'consequence of): CONCL /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and Due to (or as a consequence of) Physician/Medical Je Len Nicholson 4/2 attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ High Hood 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manne of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Lake

one Registrar's Signature

1

DOGO30 - Marylal

132 tome my 21210-1303

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 40 am Corrine I. Oneyear 2008 /Medical 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 4c. County of Death Examiner naryland Spita Grenercu 10 AMORE 5. Social Security Number Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If I Inde Date of Birth Month, Day, Year) 12/27/1920 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 ☐ XF 87 Yrs Minnesota Director 543-16-2418 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1X Yes 2 No Baltimore MD Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? United States 2230 Athol Street (Future Care Irvington) 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No þ 3 AWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Agnes F. Taylor Otto Hanson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other treu 33 Paddock Lane, Middleton, Rhode Island -2842 Mr. James P. Butler (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 05/05/2008 Baltimore, Maryland 4 ☑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) umonia **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. nding physicien Physician/Medical es the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 12 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autonsy perform 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident filled in by the Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours effer To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29b. Signature and title of centifier 29d. Date signed (Month, Day, Year) 12008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 2:55p. 04 2008 /Medical Josephine 26 Owens 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2016 Hollins Street Baltimore 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔽 F Director 251-74-7401 93 22 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> MD NA Baltimore 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2016 Hollins Street 21223 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black ģ 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 9th grade House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Int: If item 27 Is marked of Mary Cubbage Johnnie Ragin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Owens-Son 1003 Hallimont Road, Catonsville, Md 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State Arbutus Memorial Park 5/2/08 Arbutus, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death T. Enter the disease, or complications that caused the death. Do not enter the mode of dying ck, or heart failure. List only one cause on each line. diate Cause (Final **Physician** disease or condition sulting in death) /Medical Examiner Cequentiany list conuntoris, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use commute to the cause of death? Juens Division or Vital Records, þ 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home ို 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Many r of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident Director: Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of cer 29d. Date signed (Monjh, Day, Year) dress of person who co 31. Date filed (Month, Day Year, State 5 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

	3275 n Payne, III		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.
Me [.]	Physicia Heal Exami	ın/	1. Decedent's Name (First, Middle,Last) Alvin Martin Payne, III 4a. Facility Name (if not institution, give street and number) Union Memorial Hospital 2. Date of Death Month Day April 28, 2008 4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 216.44.0885 1 M 2 F 63 1 Yrs. If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD Usual Residence of Decedent 10a State 10b County 10c City Town or Location 10d Inside City Limits 10d Inside
-	Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
120%	irs after death with ural", or items 22 uniner must be m	Ē	11. Marital Status 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Detection Concepts and Decedent's Education (Specify only highest grade completed) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done) 15. Never Married 2 Married 2 Married 15. Decedent Ever in U.S. 16. Yes 2 No specify: Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16b. Kind of Business/Industry
	-0036 d within 72 hou rgiene. ther than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Tools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
	ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medica	To Be (Alvin Martin Payne, Jr. 19a. Informant's Name/Relationship (Type, Prigt) Kinberly McDevitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore 6601 Bonnie Ridge Dr. Apt. 102 MD 21209
	Baltimore, MD Department of Health and Department of Health and Important: If item 27 is		19a. Informant's Name/Relationship (Type, Prigt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code, 2ip C
	Physician 'Medical		P.A. 8717 Green Pastures Dr. Balto., MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease Atherosclerotic cardiovascular disease
		xaminer	or condition resulting in death) Due to (or as a consequence of): b.
	60, tte be executed hysician and e burial - transi	Medical E	d. X UNPENDED AMENDED #22a,27,per/ME,g879, 5/7/08 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
	Box 68760, redeath certificate be executed the attending physician and ned for use as the burial - transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
	ls, P.O. quires that the en signed by taild be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
	Record The law red ificate has bear, page 2 shou	e Completed by	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
	Division of Vital Records, P.O. Box 68760, ital or Attending Physician: The law requires that the death certificate be us after death. ral Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buril	examiner? 1 V yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; 4 Nursing Home 5 Residence 6 Other: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
	Division ital or Attend us after death.	ertification:	1 X Natural 5 Pending 1 No Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in

Medical Certi 29a. Certifier (Check only one) 29b. Signature and title of certifier

State

Registrar

allan

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

Carol Allan, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year)

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 29, 2008

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Illam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Kaver Genesis
5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Min. Months Days Hours 1 X M 2 ☐ F Director 578-09-9002 June 4, 1910 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 No Director ottinghar altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 ourts Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ò phite 3₽Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hrtist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 oseph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 Ottingham MD 21236 reven 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel + Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cremation Services 22. Name and Address of Facility Evans Funeral Chapel + Cremation 21. Signature of Funeral Service Licenses Services-Parkville 8800 Harford Rd Parkville au 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner heumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transit Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 🕱 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?
Yes 2 No this certificate has 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 217 No 2 ER/Outpatient 3 DOA 1 Inpatient filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica within 24 hours a To the Funeral I

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of

(Year)

0

H 021 death (Item 23a) (Type, Print)

0

Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 30,2008 4:15 Thelma Marie Rogers P_M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center for Hospice Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 02/01/1934 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthday) **Funeral** tsE3eM 2□ F 214-30-7307 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Important; If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Experience must be notified at Director 1 □Yes 2XXNo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Freedom Court 21220 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2XXNo Specify. Specify: 3 Widowed 4 □ Divorced White Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Manager Clothing Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madeline E. Hagen Robert Henry Sauter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Donna Rogers (Daughter) 29 Maxa Court, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 05/03/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature o Fue and Licensee 22. Name and Address of Escilitynski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER **Physician** dis se or condition resulting in death) 4EARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of) physician a the burial-P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atter for u 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 164395 APRIL 30,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 DOGURMAN, MD 6565 N CHAPLES ST. SUITE 209 BALTIMERE MD 21204 DANIEUE 31. Date filed (Month, Dev. Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 630 AM 4-25-2008 Robert Redman, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 212 Wellington Ct. BelAir Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Vaar) Days Hours Min. Months Director 216-48-1422 60 -26 - 1948Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Md. Harford BelAir 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Wellington Ct. 21014 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural once. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Account Exec. Janitora1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert C. Redman Evelyn Parris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Redman Wife 212 Wellington Ct. BelAir, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 4-29-2008 4 Donation 5 ☐ Other (Specify) Balto.Md. 21. Signature of Funeral Service Li en signature 22. Name and Address of Facility Schimunek Funeral Home 610 W. McPhail Rd. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final occircl. disease or condition resulting in death) as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 🗆 No 9 I Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform

Physician /Medical Examiner

Box 68760, certificate be

P.O.

Division of Vital Records,

or Attending

death with the Maryland

28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Modical Examines must be rightlish at

burial-transi physician the buriales nse page 2 s Certification:

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Director: Af
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Registrar

filled in by

Medical

within 24 hours a To the Funeral D the Hospital

25. Was case referred to medical examiner? 26. Place of Death (Check only o e) 1 Yes 2 Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Feat 28a. Date of Injury 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural (Month, Day, Year) Injury 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only and title of certifier 29b. Signature

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

5 Residence 6 Other (Specify)

1 ☐ Yes

29c. License number

29d. Date signed (Month, Day, Year)

2 🗆 No

(Type, Print)

31. Date filed (Month, Day, Year) 2008 5

Registrar's Signature

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			1 - For State Registrar	State of Marylan	-	ntment of H tificate of I			giene Reg. No			66
	q		1. Decedent's Name (First, Middle, Las	st)				2. Date of De	ath Da	ıy Year	3. Time of I	Death
	Physicia /Medic		MARGARET RIC	HARDSON				04	2.8		8:40	Åм
	Examin	er	4a. Facility Name (If not institution, give				r Location of Death	n	ļ	County of Deat		
			MANOR CARE ROLA 5. Social Security Number 6. S		last hirthday)	BALTIMA If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		3ALTIMO		Foreign
	Funeral Director			□M 2 1 F 85	Yrs.	Months Days	Hours Min.	(Month, Da	ıy, Year,	2 Co	nplace (State or untry) VA	- Orbigit
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside Cit	y Limits
	e Mar	ctor	M.D.	Ba	ltim	ne					1 PYes	2 No
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or Items 23a or 28a-f show event, I'te Medical Examera count be notified at	Funeral Director	10e. Street and Number 5906 I	Park Heights Ave.	Apt 412	10f. Zip Code21	1215 20 9		10g. Ci	tizen of What Co	untry?	
	ems :	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Was Decedent of H I Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, White		
0030	hours after tural', or Ite al Examèna	þ	11 Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ■No If Yes, Give Year or Dates:		1□Yes 2⊡ r No				Specify: D	lack	
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7	within 72 ene. then "ne	du	Elementary/Secondary (0-12)	College (1-4or 5+)		edical A			sing H	-		
2	filed Hygie other		12th grade 17. Father's Name (First, Middle, Last)	na	rie	dical A	18. Mother's Nar	ne (First, Middle	_		Ome	
and	D P S O	To Be	Edgar Alston				Bertha	Boone				
2	should ind Men marke umatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numb	er, City	or Town, State, 2	Tip Code)	
Ma.	s 1 and 2 shou f Health and M item 27 is mar other traumati		Edward Bailey-	Son	10 As	hlar Hi	1 Ct.,	Parkvi	.11e	, Md 2	1234	
more	9 = 5		20a. Method of Disposition 1	Removal from State		sition (Name of natory or other place d Ridge		Date 2/08		ocation - City or		
Бапттог	permit. Pa Departmer Important: any injury		21. Signature of Juneral Service Licer		Ma	Name and Address Irch F/H 300 Waba	ss of Facility West			les en	21215	
			23a. Part1 Enter the disease, or com shopk, or heart failure. List only	plications that caused the deat						e, Mu	Approximate Interval Betw	
	Physician		mmediate Cause (Final disease or condition	V		Dee	lase				Onset and D	veen Death
	/Medical		resulting in death)	a. Due to (or as a conseq	uence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-,				
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	g . / ; g	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of)!	(,	, ,	. 0				
	and	kam	that initiated events resulting in death) Last	c. Due to (or as a consec	8 Vice	Heav	1 10	num				
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08/60	ficate phys s the	edical		d	1 VVW	nor-	10 000	- Cara				
C. BOX	death cer e attendin d for use	by Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 Live birth 2 Feta 4 Pregnant at time of continuous 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)	/			23d. Date of del Month		'ear
J.	that the by detact	/ Ph	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco	use contribute to	the cause of de	eath?
SB	w requires that the been signed by the should be detache		Degenerali	re Jamt	DE	ear		1 🗆	Yes 2	2□No 3□Pr	obably 4 🗹	Inknown
Kecords	> -Q (A	olete	0					24a. Was		24b. Were au	itopsy findings a	available
	0 5 9	Completed							ormed?	death?	completion of ca 2□ No	ause of
VITAI	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only		0 , 2, 30		
01 <	d is	To E	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	at 3 DOA Oth	er: Nursing H	dome 5 ☐ Res	idence	6 □Other (Spe	cify)	
	ulng Ph After th funeral	lon;	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	rk?	28d. Describe	how inju	ury occurred		
UNISION	Attending in death.	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 390 Blood of Laiunt At h	omo form et		Yes 2 No	29f Location	(Stroot o	and Number or Ru	umi Pouto Numi	hor
2	l or Attendater death Director:	Certification:	4 Homicide determined	28e. Place of Injury - Ath building, etc. (Special	fy)	eet, factory, office		City or To			Hai Hobie Ivbiii	Der,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one)	nysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time.	cause(:	s) and manner as nd place, and due	stated. to the cause(s))
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. D	ate signed (Mont	h, Day, Year)	
	r> > 0		> pa	da	MD	D.	31464		1	11291	US	
	4		30. Name and address of person who	11	m 23a) (Type,	Print) 821 N.	EUTAW	ST -(nik	208	BALT	IMUIZ
	Sta	te	31. Date filed (Month, Day, Year)	. Registrar's Signa	ature	-/ 10.		, ,			- M12 2	21211
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Mae Backus 2008 8:10a. Ross 04 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Future Care Nursing Home Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🙀 F 578-34-3944 82 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? 5 23a Completed by Funeral 9 Spyce Mill Court 21133 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Rehabilitation Therapist State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 Is marked oth Be Allen C. Miller Mazie Burton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau once. <u>Patricia Nock-Daughter</u> Spyce Mill Court, Randallstown, Md 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore National 4/30/08 Baltimore, md 22. Name and Address of Facility
March F/H West Signature of Funeral Service License 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1 Enter the disease, or complications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi e Cause (Final cisea or condition roung in death) **Physician** /Medical Due to (or as a considuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy 2 **X**No 2 **N**0 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Donth 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

Charles Moore II 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (hem 23a) (Type, Print)

MAY 0 5 2008



4 Fast Rolling Crossroads Suite 102 Catonsville, MD 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SHIELDS EVELYN 2:30 € 2000 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) Examiner RANDALISTOWN BAUT IMORE HOSP ITAL NORTHWE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 5. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) **Funeral** 1 ☐ M 2 🕱 F Yrs. 5-30-268 land Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Funeral Director more TIMOI 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21 20 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indus ry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) eceptionist me 18. Mother's Name (First, Middle, Maiden Surname) 0 17. Father's Name (First, Middle, Last) Be 2 Mon 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IKer H 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2008 2 Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Home Balto. 2222 W. North Aue. 23a. Par J. Enter the ysease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATMARO SCEROTIL ue to (or as a consequence of): CARDIOVASCULAR **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. ed by the a detached t 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown cate has been sit, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? Yes 2 \ No Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 □ DOA ပ္ 1 ☐ Yes 1 Inpatient After this 27. Man /er of Death 28d. Describe how injury occurred 28a. Date of Injury 28h. Time of 28c. Injury at Work? Certification: (Month, Day Year) Injury Hospital or Attending 5 Pending investigation 1 ∏Yes 2 ∏No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 2008

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day,

ROTHKIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Segistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29,2008 Month **Physician** Charles Skinner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Citizens Nursing to d 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** New York Days Hours 5/24/1936 1 XM 2 ☐ F 101-28-5180 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County fshow r 28a-f show notified at 1 ☐ Yes 2 XNo Bel Air Maryland Harford County Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a United States 21014 601 C Churchill Road Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Items 23s 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security **Administration** 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vera Mae Steadman Sidney Charles Skinner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 C Churchill Road, Bel Air, Maryland 21014 19a. Informant's Name/Relationship (Type. Print) Mrs. Beverly Skinner (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot Forest Hill, Maryland 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 1, 2008 Evans Funeral Chapel 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

Byans Funeral Chapel & Cremation Center - Bel Air

3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee Jam Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or com shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) arkind on's Physician Ü /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examine physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): コメハムc、CAMIES Division or Vital Records, P.O. Box 68760, use as t attending p IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐Live birth 2 ☐ Fetal death Month in the past 12 months? Day Year 4☐Pregnant at time of death signed by the a Yes 2 No 9☐Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed?

12 Yes 2 No this certificate has al director, page 2 Medical Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA eral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Winian. TUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Pkint)

State Registrar

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. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Please I For State Registrar	ype or Print in B State of Maryland	d / Depa		f Health and N	Mental Hygie	ne2008 4426
	Physici /Medic		Decedent's Name (First, Middle, Last)	William B	ernar	d Ste	eele	2. Date of Death	Day Year 7 2008 7 2009 7
	Examin Funeral Director	40000	5. Social Security Number 6. Sex	treet and number) 7. Age (In vrs. I	ast birthday) Yrs.	4b. City, Tow If Under 1 You Months Da		8. Date of Birth Month, Day, Ye 9-9-19	4c. County of Death 9. Birthplace (State or Foreign Country) N • C •
	show	٥٢	Usual Residence of Decedent 10a. State 10b. County		, Town or Lo				10d. Inside City Limits 1
	or 28a-f	Funeral Director	MI N/A 10e. Street and Number	Ec	ourse	10f. Zip Cod		10g.	Citizen of What Country?
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service License	K. Jones		101 E	. North	March E Avenue B <i>E</i>	ALTO, MD 21202
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rds, F	requires that the een signed by the rould be detache		Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying caus	e given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Monknown
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Ö	Physician: this certific ral director,	۲.	1 ☐ Yes 2 ☑ No	1	ER/Outpatier		4 Li Nuising r	Home 5 ☐ Residend 28d. Describe how	ce 6 Other (Specify)
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)	F > F 0		> Wadi	MD		9	9611	F	tpril 26,2008
	1		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type,	Print) Uarri	Genera	Hospit	al
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	all!	1 - 1 1		

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edicai Exaiii		Walter F. Smith 4a. Facility Name (if not institution, give street and number)	b. City, Town, or Location of		4c. County of Death				
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F		Social Security Number 6. Sex 7. Age (In yrs. lateral property)	st hirthday)	Sykesville If Under 1 Year If Under	er 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Birth	pplace (State or		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	O	29a. Certifier		and at the time, date and a	<u> </u>		ad		
the H nin 24 the F	Medical	Continuer Cont	ge, death occui nd/or investiga	tion, in my opinion, death o	occurred at the time, date	e and place, and due to the	ne cause(s)		
To To COU	Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
		296. Signature and title of certifier 296. Ercense number 296. Ercense number 296. Bate signed (Month, Day, Year) O.C.M.E. May 1, 2008							
	Co Co-Citucian								
54,		30. Name and address of person who completed cause of death (Item		Street, Baltimore, MI	D 21201				
J		Carol Allan, MD Assistant Medical Examiner		oueet, baitimore, Mi					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** \mathbf{A}^M 1, 2008 6:00 Mary C. Scharmer May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lutherville Baltimore <u>Stella Maris Nursing Center</u> Birthplace (State or Foreign Country) Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/05/1914 If Under 1 Year Months Days Age (In yrs. last birthday) Social Security Number **Funeral** 1 M 2 XX 217-03-8247 Maryland 93 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 200No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 703 Christian Avenue U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣️No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Black, White, etc. 1 ☐ Never Married XX Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Social Security Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angelina Cicero Theodore Maggio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Magnolia Road, Joppa, Maryland 21085 Carol Tobash (Daughter) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' May 5, 2008 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221
Approximate 21. Signature of Funeral Service Licensee 23a. Part1 Collecting disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final dise e or condition resetting in death) Cardovasiala sclenh **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending I for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probabiy 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1□ Yes 2√No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death
Natural
2 Accident 28c. Injury at Work? Medical Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

SCHARMER, MARY

State Registrar

296. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHMOOD, M.D.

31. Date filed (Month Day, Year) 2 2008

300 DULANEY VALLEY ROAD

TIMONIUM

D43725

	241		For State Registrar	State of Ivia	aryland /	-	tificate of		a Mentai Hy	gier Reg. N	- 2 n n o	14429	
1	Physici	#	Decedent's Name (First, Middle, Last)				2. Date of Death Month				h 3. Time of I		
	/Medic		Arvindkumar P. Shah								, 2008	7:45 P M	
773	Examir	ıer	4a. Facility Name (If not institution, give street and number)				4b. City, Town,	or Location of D	eath	4	4c. County of Deat		
			Shady Grove Adventist Hospital				Rock	ville			Montgomery		
35 ₄ &	Funeral Director			6. Sex 7. Age (In yrs. last birthday Yrs. 59 Yrs.					Hrs. 8. Date of Bi (Month, Di Sept 2	ay, Yea	9. Bird 1948	hplace (State or Foreign untry) India	
	land ow		10a. State 10b. County		10c. City, To	own or Loc	cation					10d. Inside City Limits	
	Mar)	to	Maryland Montgomery Gaithersburg						1 XYes 2 No				
	th the or 28,	Director	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	untry?	
	23a (ust b	Ta L	7 Outpost Court				208	878			United S	tates	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notifiled at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent of Armed Forces? 1 Yes 2 If Yes, Give Year or Dates;			Vas Decedent of I f Yes, specify Cub ☐ Yes 2【▼No		? (Specify Yes or No uerto Rican, etc.))-	14. Race - Ame Black, Whit		
21215-0036	2 hou atura cal E	ed	15. Decedent's Ed	ucation	16	6a. Deced	ent's Usual Occu	pation		16b.	Kind of Business/		
215	hin 7. e. an "n Medi	Completed	(Specify only highest grades Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	(Give I life. D	kind of work done OO NOT use retire	e during most of ed)	working				
	d wit	Son		5+	A	ccour	nt/Vice	Preside	nt	P	roperty 1	Management	
Maryland	be file tal Hy d oth event	Be (17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	, Maid	len Surname)		
<u>ya</u>	ould Men arke	은	Purushottam	V. Shah					aben P.	Sh			
Jar	2 sh and is m		19a. Informant's Name/Relationship (7						r Rural Route Numl				
	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		Reeta A. Shah/wi	lfe					ithersbur				
Baltimore,	Pages hent of Hant. If ite		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				sition (Name of natory or other pla lel Crema		Date / 28 / 2008		Location - City or enton, Ma		
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licent	Amor		22 I 1 2	Name and Addr Donaldson	ess of Facility n Funera	al Home & oad Odent	Cr	ematory,	P.A.	
	*		23a. Part . Enter the disease, or composition or heart failure. List only of		the death. D							Approximate	
	Physician		Immediate Cause (Final disease or condition	one dadd on daeri iii					CANCE			Interval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as			•						
44	Examiner		Sequentially list conditions.	b									
1	po tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequend	ce of):							
V	xecut and I-tran	хаг	that initiated events resulting in death) Last	c	a consequenc	ce of):							
68760,	icate be executed physician and s the burial-transit												
687	tificate ig phys as the	edical		d									
P.O. Box (The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea	ath 3□	Ectopic pregnand Other <i>(specify)</i>	СУ			23d. Date of del Month	ivery Day Year	
ω. Ω.	res that igned b	by Pi	Part II. Other significant conditions co	ontributing to death be	ut not resulting	g in the un	derlying cause gi	ven in Part I.	23e. Did	tobacc	o use contribute to	the cause of death?	
ığ	w require been sig should b								_ 1□	Yes	2 No 3 P	obably 4 Dnknown	
Records,	The law requirate has been page 2 should	Completed							24a. Was auto	DSV	prior to	utopsy findings available completion of cause of	
tal			25. Was case referred to medical					OC Disease		2 🔼	No 1 ☐ Yes	2□ No	
or Vital	Physician: this certificated director, I	To Be	examiner?	Hospital: 1 Inpatie	nt 2∏ER/	Outpatient	t 3 DOA Ott	hau	Death (Check only ig Home 5 ☐ Res		6 DOthor (Spe	0:64	
0			27. Manner of Death	28a. Date of Inju	ry 28t	b. Time of	28c. Inju	ıry at	28d. Describe			cny)	
io	ath. rr: After ne funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		rear)	Injury		ork?]Yes 2∐No					
Division	after death after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuilding, etc	ry - At home, c. (Specify)	farm, stre	eet, factory, office		28f. Location City or To			ıral Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	a		ysician: To the best of the basis of and manner sta									
	To the within To the comp	Me	29b. Signature and title of certifier 30. Name and address of person who compared to the comp	alllan	1		29c. Licen	se number 4251	8	29d. [PRIL	n, Day, Year) 25,2008	
	20		30 Name and address of person who of	completed cause of de	eath (Item 23a	a) (Type, F	eswu	ce Pite	P#401	R	24417	MD 2000	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1-0		7 100	11. 70/			0000	
	Registi	ar	MAY 0 5 20	08 80	as St	Ago	ALA!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 14430 State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

Fark David Alan M8003014 Bivision or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be execution within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran 6

1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	th Day	Year	3. Time of D	eath
David Allen Sta	rk				04-25-2		1 Gai	1735	\mathbf{P}^{M}
4a. Facility Name (If not institution, g			4b. City, Town, or L	ocation of De			ty of Death		
Upper Chesapeak	e Hospital		Bel Aiı				ford		
	Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Day	, Year)	9. Birthpla	ace (State or ry)	Foreign
542-68-0350	50	Yrs.			12-06-1	957		CA	
Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ly, Town or Lo	cation				10	d. Inside City	/ Limits
Maryland Harfor	cd	Havre	de Grace					1 ☐ Yes	2 X]No
10e. Street and Number			10f. Zip Code			I0g. Citizen o	f What Count	ry?	
3710 Rock Run Ro	1		21078			USA			
11. Marital Status	12. Was Decedent Ever in U.	.S. 13. \	Was Decedent of His If Yes, specify Cuban	panic Origin?	(Specify Yes or No-		ace - America	an Indian,	
1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 M Yes 2 □ No If Yes, Give				ierto Rican, etc.)	BI	lack, White, e	etc.	
3 ☐ Widowed 4 🏋 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2☐ No	Specify:		Spec	oify: Who	ite	
15. Decedent's	Education		dent's Usual Occupat		working	16b. Kind of	Business/Ind	ustry	
(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done du DO NOT use retired)	ning most of t	WOLKING				
12	g- (Line				Veriz			
17. Father's Name (First, Middle, La	st)			18. Mother's N	Name (First, Middle,	Maiden Surn	ame)		
Lee E. Stark				Lois	s I. Walsh	L			
19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street ar	nd Number or	Rural Route Numbe	r, City or Tow	vn, State, Zip	Code)	
Lois Stark (Mot	cher)	12920	O SW Edgew	vood St	Portland	, OR 9	7225		
20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place)	Date	20c. Location	n - City or To	wn, State	
1 ☐ Burial 2 ⚠ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	,	Crematory	i	-30-2008	Balti	more,	MD	
21. Signature of Funeral Service Lic			2. Name and Address		Schimunek				1 / 4
Makerino	RIMORN		nc. 610 W.						: LA1
23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the deat	th. Do not ent	ter the mode of dying	, such as care	diac or respiratory ar	rest,	110_21	Approximate Interval Betw	
Immediate Cause (Final	ly one cause on each line.		tine In	(Onset and D	eath
Sequentially list conditions, y section cut cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as a consequence. Due to for as a consequence.								
						-		·	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3[□Ectopic pregnancy □ Other (specify)				Date of delive Month		ear
Part II. Other significant condition	s contributing to death but not res	sulting in the u	inderlying cause give	n in Part I.	23e. Did to	obacco use co	ontribute to th	e cause of de	eath?
					1 🗆 🤄	res 2□No	o 3 <mark>x</mark> Prob	ably 4 □U	nknowr
					240 18/00	an 24	h Wara suta	psy findings a	nyailah!
					- 24a. Was autor			npletion of ca	
					1□ Yes	2 No	1 Yes	2□ No	
25. Was case referred to medical examiner?	Hemital: 1		Tou		Death (Check only o	ne)			
1 ☐ Yes 2 No		ER/Outpatie		4 LI Nursir	ng Home 5 Resid			y)	
27. Manner of Death 1 Natural 5 Pending investigat		28b. Time o Injury	Work	at ? ′es 2 □ No	28d. Describe I	now injury occ	curred		
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine			reet, factory, office		28f. Location (S City or Tov	Street and Nu vn, State)	mber or Rura	l Route Numi	ber,
29a. Certifier (Check only one) Certifying Medical Ex	Physician: To the best of my know caminer: On the basis of examine and manner stated.	nowledge, deat nation and/or in	th occurred at the tim nvestigation, in my op	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and date and plac	manner as so ce, and due to	tated. the cause(s))
29b. Signature and title of certifier	6		29c. License	number		29d. Date sig	ned (Month,	Day, Year)	
I Man AR	Alleman in		70 0	171.31		Anr.	128	Dong	7
30. Name and address of person w	no completed cause of death (Its	m 23a) (Tyro	Print)	0001	,	- Y11	100	2000	100
Ronald Tho	mas m.b. 34	145 E	Box H	11 Cor	porate Ce	nterD	r.Abi	ngdon, i	m <u>D</u>
MAY 0 5	2008	IN A	pode						

State

Registrar

MAY 0 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 25, 2008 10:30 A M EVELYN SIMS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SOUTH LANE TURNER STATION BALTTMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Year Hours 1 M 2 X F 12-20-1952 MD Director 213-62-2179 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" ~~ ** any injury or other traumatic event. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State XXYes 2 No Director TURNER STATION MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA SOUTH 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 XIII If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 Married 1 ☐ Yes 2 █No Specify: 3 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HEALTH 12 NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NANNIE RUTH BRANDON REGINALD CHAMBERS ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 SOUTH LANE BALTIMORE, MARYLAND 21222 THEODORE SIMS/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Catonsville -2-08 bulus NIZM 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licenses 1701-31 LAURENS ST. BALTIMORE, MD 21217 a. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Covonaur disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner erpusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Astrino 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Certification: To

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit this certificate has but director, page 2 sh 24 hours a within 2

		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ██No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 🕅 Residence 6 🗆 Other (Specify)
27. Manner of Death 1 ★ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	8d. Describe how injury occurred
3 Suicide 6 Could not be determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)
	Physicien: To the best of my knowledge, death occurred at the time, date and place and manual miner: On the basis of examination and/or investigation, in my opinion, death occurre	

29c. License number

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. LUZERNE AU , BALTIMORE MD 21224

^{Year)} 5 2008 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Margaret Sawicki 71200.M may, 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Total, or Location of Death Examiner 4050.40 LIMOR Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1□M 2□xF Months Min. May 5 1 922 Days Hours 215-14-7615 85 Yrs MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notifled at Baltimore MD Essex 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1218 Evergreen Lane 21221 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🛣 No Specify. Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Lucent Tech 8th Item 27 is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph P.O'Donnell Anna Crist ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Braden-Tilghman 1218 Evergreen Lane Baltimore MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If It any Injury or o 2/☐Cremation 3 ☐Removal from State 1 ☑ Burial 4 ☐ Donați Cedar Hill Cemetery5/5/08 Baltimore MD 5 Other (Specify) Fun tal Service Liver see 22. Name and Address of Facility 21. Signal r 300 Mace Ave.Baltimore MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final MUNIONIA Physician au disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No Records, P.O. 9 Unknown 9 Unknown Part II. Other-eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s 1☐ Yes Vital Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 0 this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier (Check only one) X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 2746 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

Year)

MAY 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yeleaa hpmx, 720 warlen Clisice Lone

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 🗎 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Deedent's Name (First, Middle, Last) Month Day Year **Physician** 9:12 A Schininsky Sosalie 2 2008 04 ٦ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A FUTURECARE CANTON HARBOR BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F MARYLAND 95 216-01-8556 67-15-1912 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a 521 S. LINWOOD AVENUE 21224 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ WHITE 3 Widowed 4 ☐ Divorced netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ELIZABETH JOSEPH NOTO KLEE ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 S. LINWOOD AVENUE, BALTIMORE, MD. 21224 STANLEY SCHIMINSKY/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ŏ permit. Page Department of Important: If any injury or `4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 4/30/08 BALTIMORE, MARYLAND 21. Signature of Funer ice Licensee LTLTY & CTETLER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician a Hyperteries Corney Artur Drose years. /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) the attending physician hed for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Honknown Lecident. orehoover welan Completed 24b. Were autopsy findings available prior to completion of cause of death? Phesiatoid As Turily 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 **□**₩6 completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 1 Inpatient 2 ER/Outpatient 3 DOA P 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After 1 PNatural 5 Pendina 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

31. Date filed (Month, Day, Year) MAY 02 2008

ewours.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

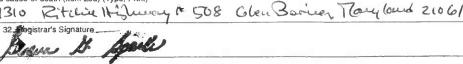
7310

answers

29b. Signature and title of certifier

James J.

Horace



29c. License number

D19667

29d. Date signed (Month, Day, Year)

04-30-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPMS 30 per H (879 5/2/08 WS
State of Maryland / Department of Health and Mental Hygiene (1) [1] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician TRUDE 04 008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Date of **88** (Month **18**) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗡 F Months Days Hours Min. NY 91 067-03-0404 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show r items 23a or 28a-f show 1 □Yes 2 No MD MONTGOMERY SILVER SPRING Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 14514 HOMECREST RD., APT. LL-1 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2\(\text{No} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates: Be Completed by 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H FINKELSTEIN SILVERMAN JENNIE CHARLES ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant: If item 27 is r 3910 HARVARD STREET, WHEATON, HELENE KRAUTHAMER / DAUGHTER MD 20b. Place of Disposition (Name of cemplers, crematory prother place)
MEMORIAL GARDENS 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State ō permit. Page Department of Important: If any Injury or 05/01/2008 HOLLYWOOD, FL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 DNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Montly, Day, Year) D0062261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Inpatient Sercives Washington Co. Hospital Sadik M. Ali 0sler State 31. Date filed (Month, Day, Year) Registrar's Signature

Registrar
DHMH 17 Rev 1/2001

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Funeral Director			Sex 1 □ M 2 F 7. Age (In yrs. 92	last birthday) If Under 1 \ Yrs. Months D		8. Date of Birth 04/06/19	(ear) 9. Birthpla Counti	POLAND
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Exemits in must be notified at angles.	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	S. 13. Was Deceden If Yes, specify	t of Hispanic Origin? (Spi Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify: WHITE	c.
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Sta Regist	ate	31. Date filed Month, Ray2 Year	32. Registrar	s Signatur	CASA!	2)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item: State of Maryland Bepartment of Abalth and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month -PAI **Physician** 3 5M UUZA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 6110 Arbroath Drive If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 123 12 1624 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. M 2□F 84 1924 Director Feb 3. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location i and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show raumatic event, I'm Mydral Examiner must be notified at 1 ☐ Yes 2 ☐ No MD P.G. Directo Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 United States by Funeral filed within 72 hours after death v Hygiene. 6110 Arbroath Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ™Yes 2 □ No If Yes, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be flik Department of Health and Mental Hi Important: If item 27 is marked oth any injury or other traumatic event Be Augustine Souza Mary C. Cambra ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6110 Arbroath Drive, Clinton MD 20733 Date 200. Location - City or Town, State Kenneth Souza (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) May 3, 2008 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Z001 **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ending physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, pe Physician/Medical attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) sate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifier. d cause of death (Item 23a) (Type, Print) Name and address of person who come 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ruth E. Thomas 2008 MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death Eacility Name (If not institution, give street and number **Examiner** BALTIMOTE KosedAle Hospital 8. Date of Birth (Month, Day, Year)
NOV • 6 , 1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days West Virginia 1 □ M 2 🕱 F 228-18-6455 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show if Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Middle River Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 USA 3818 Clarks Point Road Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 🏋 No Specify: Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Harman Betty Blana ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Thomas / husband 3818 Clarks Point Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊈Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If It any injury or o 5/5/08 Rossville MD Gardens of Faith 4 Donation 5 ☐ Other (Specify) 21. Signature of Fu ral Service Sicensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list no dilease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 4□Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform certificate 2 No 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? al Director: After the Certification: 5 Pending investigation 1 Matural 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

back

of person who completed cause of death (Item 23a) (Type, Print)

2008

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			For State Registrar	State of Maryl		rtment of H tificate of L			ene j. No. 2 () () 8	14439
ľ	Physicia	an	Decedent's Name (First, Middle, Last,		HOWARD	TAYL	OR, SR.	2. Date of Death Month MAY 01	Dav Year	3. Time of Death 5:00 A M
1	/Medic Examin		4a. Facility Name (If not institution, give	35 01111			Location of Death		4c. County of Deat	h
			2662 PATAPSCO		and the sale from the sale of	FINKS		8. Date of Birth	CARROL	hplace (State or Foreign
ı	Funeral Director		5. Social Security Number 6. Sec. 120-14-3543	x M 2□F	yrs. last birthday). 84 Yrs.	Months Days	Hours Min.	(Month, Day, Y	rear) Co	RYLAND
	D		Usual Residence of Decedent	Lin	Oit. Town and a			00/04/	1223 111111	10d. Inside City Limits
	larylar show	J.	10a. State 10b. County CARRO		FINKSB					1 ☐ Yes 2 X No
	the N 28a-f notifie	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	untry?
	th with		2662 PATAPSCO	RD.		2104	8		USA	
	items	Funeral	71. Wartar States	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 2 No	in U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
336	be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	1 □ Yes 2 🛣 No	Specify:		Specify: WH	HITE
5-0036	72 hou natura dical E	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	I (Give	lent's Usual Occup	lurina most of worki		6b. Kind of Business/	Industry
121	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired OWNER	,	P	AVING CO	OMPANY
0	illed Hygid other ent, th	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	aiden Surname)	
/lan	should be filed within 72 hours after death with the Marylar and Mental Hyglene. Ind Mertal Hyglene. Is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	To B	G	ROVER	TAYI	LOR	BLANC	HE	WAC	GNER
Maryland	an sa		19a. Informant's Name/Relationship (T) WAYNE TAYLOR	/pe. Print) - SON		,			City or Town, State, 2 URG $_{m{ extit{P}}}$ MD 2	
altimore,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20 Removal from State	0b. Place of Disport cemetery, cren	sition (Name of matory or other place	re)	Date 20	Oc. Location - City or	Town, State
Ĭ	permit. Pages Department of I Important: If It Important: or o		4 Donation 5 Other (Specify)	E.V					INKSBURG	
Ba	permit Depar Impor any ir		21. Signature of Futeral Service Licens	ee					INSTER,	HOME, P.A. MD 21157
	Physician /Medical Examiner	Examiner	23a. Part. Ent. Le disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a	nsequence of):	nc C	Ab/An	SW CA	CINAMA	Approximate Interval Between Onset and Death
8760,	cate be executed bhysician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a cor	nsequence of):		-			
Box 6	The law requires that the death certifical te has been signed by the attending phyage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months. 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
ds, P.0	uires that the signed by id be detacl	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part i.	23e. Did toba		o the cause of death?
I Records,	The law require ate has been sig page 2 should b	Completed					-	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital: , ,		oth Oth	or:	h (Check only one		
	Attending Physician: The sr death. ector: After this certificate he ector; After this certificate he by the funeral director, page	: To	1 Yes 2 100	28a. Date of Injury	2 ER/Outpatier 28b. Time of	IL SUI DOA	4 Nursing Ho	me 5 X Resider 28d. Describe hov	nce 6 Other (Spe w injury occurred	ecify)
Ö	ath. ir: Afte	atior	1 Natural 5 Pending investigation	(Month, Day Yea	ar) Injury		Yes 2 □ No			
Division or	l or Attencatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) Certifying Phy	rsician: To the best of my iner: On the basis of exa and manner stated.	mination and/or in	h occurred at the til evestigation, in my o	me, date and place, ppinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
/			20 Name and addressed	omploted source of do-th	(itam 22a) (5-m	1) 6	ا درر		2/1/2	رد نوا
(12)		30. Name and address of person who co	completed cause of death	L COL	Eu St.	WESTY.	ruster.	MUDIL	57
	Sta Registi		MAY 0 2 200	3 Registrar's S	Signature Apa	while the				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Month 38 am Charles E wilson 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University of Meryland If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

MARVLAND 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** 1 M 2 □ F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 1

Yes 2

No Director 10e. Street and Number Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If Item 27 is marked other tha any injury or other trainmasts. MANUFACTURING (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VERNON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEE FRIEND BALTO. MD 21223 THELMA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial, 2 ☐ Cremation 3 Removal from State EMETERY 05-06-08 LANSDOWNE. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN -BROWN JR. FUNERAL HOME 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rute /Medical Due to (or as a consequence of) Examiner h+ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi and Due to (or as a consequence of): Records, P.O. Box 68760. attending physician for use as the bunal Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No Division or Vital the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner?
1 → Yes 2 □ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Adatural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 0060292

Registrar

DHMH 17 Rev 1/2001

State

5. Greene

altimore. MD 21201

Physician

22

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mengtier

MAY 0 2 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Wilson 10:15 PM Leila F. April 28, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Mitchellville Collington Nursing Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 😿 F 96 March 30,1912 New York 181-38-0320 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f sh notified a 1 ☐ Yes XXXNo Mitchellville Prince George's Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number pe or filed within 72 hours after death with 10450 Lottsford Rd. 20721 United States "natural", or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 💢 No Specify: Specify: White ò 3 TyWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If Item 27 is marked other tha any Injury or other traumatic event, the Jones. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James B. A. Fosburgh Leila Whitney ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Wilson / Daughter 3800 N. Farfax Dr. #1014, Arlington, VA 22203 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/30/08 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service License 933 Gist Ave. 22. Name and Address of Facility 20910 M00382 Rapp Funeral & Cremation Sers.Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Immediate Cause (Final 1EAW **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): OBSTRUCTIVE PULMONARY DISEASE PONIC Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transi Page 4 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by the detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 GESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔭 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760, Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed or Attending Hospital

To the musping within 24 hours after death.

To the Funeral Director: Af

20

Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

MAY 0 2 2008

29b. Signature and title of certifier

and manner stated.

D0066658

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover

Suite 101A Greenbelt Par Kway

32. Registrar's ignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 1:40 PM M 2008 April 25, William R. Wood 4c. County of Death 4b. City, Town, or Location of Death acility Name (If not institution, give street and number) Montgomery Derwood **Hospital** Montgomery General Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Days 1**⊠**M 2□F 04/04/1938 70 526-46-1915 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 🕱 No Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20905~ 17235 Donora Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Year or Dates: 3 Widowed 4 Divorced 1961-1964 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Soil / Foundation Elementary/Secondary (0-12) College (1-4or 5+) Investigations Geologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Detweiler George E. Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17235 Donora Rd. Silver Spring, MD 20905-Marcia B. Wood/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Apr 30 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Beltsville, Maryland

2008

Physician /Medical **Examiner**

Physician

/Medical

Director

Funeral

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Completed

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4 □ Donation 5 □ Other (Specify)

MD

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and within 24 hours after dea To the Funeral Directo completely filled in by th

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

21. Signature of Funeral Service License	mann_	22. Name and Address of Facility Rapp Funeral & Cro 933 Gist Ave. Si	emation Servi lver Spring,	ces Maryland	20910-
23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death. Do not e cause on e och line.			8	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	rohe Carelinya	scular dis	CARE	Year
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions con	tributing to death but not resulting in the Cary				o the cause of death? robably 4 TONKnown
	0		24a. Was an autopsy performed	? d <u>ea</u> th?	utopsy findings available completion of cause of
25. as case referred to medical examiner?	41		Death (Check only one)		
1 Yes 2 No chelmen	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA Other: 4 Nursin	g Home 5 ☐ Residence	6 □Other (Spr	ecify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Ti	me of 28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	jury occurred	
3 ☐ Suicide 8 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, fame building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, St		Bural Route Number,
 29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ner: On the basis of examination and and manner stated.	death occurred at the time, date and pi/or investigation, in my opinion, death o	lace, and due to the cause occurred at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
control of the state of an elifter	.00 / 0	20c License number	204	Date signed (Mon	th Day Vear)

Chesapeake Crematory

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

All In Mr. 1810; Print Ph. I.p Dr. Oliney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12,29d per fh/dr. 8879.05/02/08/hb 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Wilson 23 James 2008 100 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner hitchie Joseph cial Security Number saltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore **Funeral Director** MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 stonewood Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 140 Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 Z No Maryland 21215-0036 Specify Black þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item Z7 Is marked othe any injury or other the contract of the state of th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) *ames* Lee Wilson ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1635 Stonewood Ad Baltimore, Mil 21239

20c. Location - City or Town, State Wilson Angela 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Oremation 3 Removal from State Baltimore, MD Greenmount Crematory 5/1/2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License vougno C. Greene Funeral services 22. Name and Address of acility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on earn line. 4905 York and Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Physician/Medical Examiner death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death3 conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 4 Unknown 3 ☐ Probably 1 🗌 Yes 2 🗌 No Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 certificale Division or Vital Hospital or Attending Physician: 25. Was case referred to hedical examiner? 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 6 (Specify) 28a. Date of Injury (Month, Day Year) 27. Manufer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation within 24 hours after deam.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day) 423/2008 29c. License number 29b. Signature and title of certifier person who co ay, Year) 05 State 2008 Registrar

DHMH 17 Rev 1/2001

7:05am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day April 25 2008 0115 Hilda Leona Alexander /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Ceci1 E1kton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Months Days Hours Director 218-32-9247 SEPT 8, 1927 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at 1 ☐ Yes 2 📉 No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 items 23a 112 Beech Drive 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🚻 No Specify: b If Yes, Give Year or Dates: 3 X Widowed 4 Divorced Black "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical.] once. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Motor Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Cecil Wesley Ella Mae Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline B. Jones/Daughter 31 Hatteras Court, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Delaware Veterans April 30, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2008 Bear, DE Memorial Cemetery 22. Name and Ad ress of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Lice 21921 23a. Part1. Enter the disease, or o shock, or heart failure. List nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (First disease or condition resulting in death) corrence **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ No 3 Probably 4 Unknown Completed ANIEMIA 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has b DYSPHAGIA POLESSION Yes PHNo 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 atural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760,

State Registrar

9

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

UNION

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MOSPITAL

29c. License number

D0063730

29d. Date signed (Month, Day, Year)

4125108

ELILTON NO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 April 26, 3:45pm Dorothy Virginia Arvin 4a. Facility Name (If not institution, give street and number) 3865 Jefferson Pike 4b. City, Town, or Location of Death 4c. County of Death Jefferson Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 1 M 2 X F 220-28-8932 93 Feb 9, Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland Jefferson Frederick 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3865 Jefferson Pike 21755 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No 3x Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clayton Oscar Smith Rebecca DeGrange Carrie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Reba Wright, Daughter 4133 Horine Road, Jefferson, Maryland, 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery Apr 29, 2008 Jefferson, Maryland 4 Donation 5 Dother (Specify) ^{22. Name and Address of Facility} Rasford P.A. Funeral Home 21. Signature of Funeral Service License 106 East Church Street, Frederick, MD Approximate Interval Between Onset and Death 23a. art Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Immediate Cause (Final rastulhtstindisease or condition resulting in death) Due to (or as a consequence of) Mleran Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes Z No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed physician and Division or Vital Records, P.O. Box 68760, the as attending signed by t peen has page certificate Hospital or Attending Physician:

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification:

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Funeral

Director

t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene.

rtant: If item 27 is marked other than "natural", or items 23a or 28a-f show njury or other traumatic event, the Medical Examiner must be notified at

permit.
Departn
Importa
any inju

Physician

/Medical

Examiner

more, Maryland 21215-0036

filled in by the funeral after death within 24 hours a To the Funeral C

Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Christopher Fleming, M.D., 610 Ninth Avenue, Brunswick, Maryland 21716-1828

MAY 0 2 2008

3. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D37178

29c. License number

29d. Date signed (Month, Day, Year)

April 29, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 04-10-08 Year HAOP M **Physician** Ida H. Atchison /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Westminster If Under 1 Year | If Under 24 Hrs Center Carroll 8. Date of Birth ce (State or Foreign Age (In yrs. last birthday) **Funeral** Days 218-38-5407 1□M 2□ Months Hours 11/30/1940 NY 67 Director Usual Residence of Decedent 10c. Cify, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director PA Adams Littlestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or a 70 W.Summit Drive 17340 пs 23a с USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Mo If Yes, Give Year or Dates: 14. Race - American Indian, "natural", or Items edical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 3 College (1-4or 5+) the Me Elementary/Secondary (0-12) Payroll Clerk Pharmaceutical d other event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked oil any injury or other traumatic ever once. Edgar W.Hess Hulda Ingram 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , Husband 70 W.Summit Drive Littlestown, PA17340 Doug Atchison
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery4/15/08 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Little's FH 34 Maple Ave.Littlestown, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYELOFIBROSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the charge Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physlcian: The law requires that the death certificate be executed physician and the burial-transit Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30263 1-10-08 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis Khoo, MD 200 Memorial Ave. Westminster, MD21157 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2008 Elecur Registrar

Physician

For State	riea	State of	of Maryland	d / Depa		f Health	and N	_	ygiene	9	ne.	· 1 I	[_ 17
Registrar	- /Fina Mind	- (4)		Ce.	rincale (or Dealli		2. Date of [Reg. No		117	I la la	13
Decedent's Name								Month	Death Da	y 2	Year	3. Time of [
JOSEPHII			una fi a ul		4h City Toy	m or Location		APRIL			008	8:55A	M M
WILLIAM	HILL N				EAST					County o	LBOT		
Social Security N	lumber	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Y Months Da	ear If Under ays Hours	24 Hrs. Min.		Day, Year,	101	Coun		Foreign
072-46-77			92	115.				SEPT.	14,	1915	BE	LGIUM	
Usual Residence of 10a, State	10b. County		10c. City,	Town or Lo	ocation						1	0d. Inside City	/ Limits
MD	TAI	BOT		EA	STON							Yes	2 No
10e. Street and Nur	mber				10f. Zip Co	de			10g. Ci	tizen of W	hat Coun	ntry?	
501 DI	UTCHMAN	IS LANE				21601				U	SA		
11. Marital Status		12. Was Dec Armed F	edent Ever in U.S orces? 2 No	13.	Was Decedent If Yes, specify	of Hispanic Or Cuban, Mexica	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	No-		- America	an Indian, etc.	
1 ☐ Never Marr 3 X Widowed		If Yes G	ive	1	1 □ Yes 2 X					Specify:			
(Spec	15. Deceden	t's Education st grade completed)		(Give	dent's Usual O kind of work d DO NOT use re	one durina mos	st of work	ing	16b. K	(ind of Bus	siness/Inc	dustry	
Elementary/Seco	ondary (0-12)	College (1-4or 5+)		IOMEMAKI					OWN	HOME		
17. Father's Name						-		e (First, Midd			<i>'</i>		
		A VAN HEI	SCH					ARIA C					
19a. Informant's Na					ng Address <i>(St</i> 109 WAVI							,	
20a. Method of Disp		•	20b. Pla	ace of Dispo	sition (Name o	of		Date		ocation - (
	Cremation	3 □Removal from	State		matory or other	i i	TR 4	/14/20					
21. Signature of Fu	ineral Service	Licensee	, 02233	2	2. Name and A	ddress of Facil	ity						
1	P	. MER	RIERON	FF	LLOWS.	HELFEN ARRTSON	BEIN	& NEW	NAM I	7UNER 2160	AL H	OME PA	
23a. Part1. Enter t shock, or hea	he disease, or art failure. List	complications that only one cause on	caused the death.							_2100		Approximate Interval Betw Onset and De	/een
Immediate Cause (disease or conditio resulting in death)	(Final n	a	conge.	AM	IN L	1-con	0	tar	ur	11	2: .	days	
resulting in deathy		Due to	r as a nsequ	ence f):	1	DI SON	1.		//	7	-	1	
Sequentially list co	nditions,	b.01/1	TO TO	Ken	1 dec	No	1000	ercu	ar	d14	Park	- Ge	err
Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	nmediate rlying	Due to	(s a conseque	ence of):	,							/	
that initiated events resulting in death) I		C	/							_			
resulting in doctary i	Luot	Due to	(or as a conseque	ence or):									
		d			· · · · · · · · · · · · · · · · · · ·								
IF FEMALE:													
23b. Was deceden			itcome pf pregnar birth 2 □ Fetal		∃Ectopic pregn	ancy				23d. Date		,	
in the past 12 1 ☐ Yes 2 ₽	No	4□Preg 9□Unkr	nant at time of de	ath 5[Other (specif	y)				Mor	ntri	Day Yo	ear
9□Unknown					,								
Part II. Other signif	ficant conditie	ons contributing to o	leath but not resul	ting in the u	nderlying cause	given in Part	l.	23e. Did	d tobacco	use contri	bute to th	ne cause of de	eath?
12	n-	y M.	ever)	ch	m Enf			1 [Yes 2	!□ No	3 ☐ Prob	abiy 4 📈 U	nknown
b	126	21110	M	2/12	UNIA	15741		24a. Wa		24b. W	/ere auto	psy findings a	vailable
(1	700			au pei 1∐ Yes	topsy rformed? 2 2 No	/ d	eath?	mpletion of ca 2□ No	use of
25. Was case refer examiner?		Hospital:			-1	0.1		h (Check only					
1 Yes 2₽		1 1		R/Outpatier			ursing Ho	ome 5 Re				y)	
27. Manner of Deat 1 ☐ Natural	5 Pendin	ig .	of Injury oth, Day Year)	28b. Time o Injury		Injury at Work?		28d. Describ	e how inju	iry occurre	ed		
2 Accident	investig 6	gation				1 ☐ Yes 2 ☐	No						
3 ☐ Suicide 4 ☐ Homicide	determ	ined Zoe. Flat	e of injury - At hor ling, etc. (Specify,	ne, farm, sti	eet, factory, of	fice		28f. Location City or T	(Street a	nd Numbe e)	r or Rura	I Route Numb	oer,
29a. Certifier (Check only one)		ng Physician: To th Examiner: On the tand mar											
OHE)													

Registrar

State

4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of Maryla	nd / Dep		Health and M	lental Hyg	0.0110	43
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	th	3. Time of Death
и	Physici		Anna	Virginia		Aldridge		Month	Day Year 13, 2008	1955 P M
	/Medi Examir		4a. Facility Name (If not institution, give				or Location of Death	April	13, 2008 4c. County of Death	1955 P
	LAGIIII	iei	Allegany Co Nurs		onton	1				
	Funenal		5. Social Security Number 6. S		ast birthday		erland If Under 24 Hrs.	8. Date of Birth	Q Rieth	egany place (State or Foreign
	Funeral Director			□M 21xF 93	Yrs.	Months Days	Hours Min.	(Month, Day	Year) Cou	intry)
			Usual Residence of Decedent	75		1		12/11/	1914 Ma	ryland
	/land		10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	Many Figh	ò	MD Alleg	anv	C	umberland				1 X Yes 2 ☐ No
	28a	Director	10e. Street and Number			10f. Zip Code		T-	0g. Citizen of What Cou	inter?
	with a or	□				Toi. Zip Code		'		iiity:
	s 23	Funeral	603 Henders		10 10		21502	'' M	USA	
	item item	Ğ	11. Marital Status	12. Was Decedent Ever in I	J.S. 13.	If Yes, specify Cub	lispanic Origin? (Spean, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White	
36	rs af	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1□Yes 2√2No	Specify:		Specify: Tr	. • 4
21215-0036	within 72 hours after death with the Maryland ene. ene. Then "naturel", or liems 28a or 28a-f show re Madical Examiner must be multified at	교	V		10. 0					hite —————
<u> </u>	ina ina	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done	during most of works	ng	16b. Kind of Business/Ir	ndustry
2	Per Per Per Per Per Per Per Per Per Per	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	DO NOT use retire	<i>a)</i>			
N .	Hygie ther ant, II	ပိ	12 17. Father's Name (First, Middle, Last)			Homema		- 3	Home	
⊆ .	be f htal h	Be	17.77.	7	α.	0	18. Mother's Name	i (First, Middle, I		
<u>×</u>	should nd Men marke umatic	ြ		Joseph	Schu		Pearl		Eversole	
ָ שַּ	and and ls m		19a. Informant's Name/Relationship (7	урө, Print)	19b. Maili	ing Address (Street	and Number or Rura	il Route Number	, City or Town, State, Zi	o Code)
	and lealth m 27 her tr		James L. Wilt / S	on	603	Henderso	n Avenue,	Cumberl	and, MD 2	1502
•	~ 1 0 ~		20a. Method of Disposition		Place of Disp	osition (Name of matory or other place			20c. Location - City or T	own, State
Ĕ	Pages nent of int: If it iry or o		1 ☐ Burial 2X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		-		tory 04/1	1/2008	Cumberland	4 MD
=======================================	nit.		21. Signature of Funeral Service Licent						ly Funeral	
ñ	Depa Impo any ir		Man X (March			ur Street			21502
			23a. Part. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea						Approximate
	nysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. CALDIDVA Due to (or as a conse	quence of):	AR, H	YPERTE	PSIVE	PISEASE	Onset and Death
/6U,	ate be executed hysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse						
-				d						
. Box	e attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 WNo 9 □ Unknown	23c. If yes, outcome of pregn 1□Live birth 2□Fet 4□Pregnant at time of 0 9□Unknown	al death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delive	ery Day Year
ords, P.O	signed b	by	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
	houl	ete								
H H	ate has page 2	e Completed	25. Was case referred to medical				26. Place of Death	24a. Was ar autops perform 1 Yes 2	prior to co death? 1 Yes	psy findings available impletion of cause of
a	is cer direc	OB	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outnation	nt 3 DOA Oth			nce 6 Other (Specif	
VISION OF	9 9 9	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injun World	y at 2		w injury occurred	y)
ST A	after death. I Director: Af	ţi	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str	reet, factory, office	12	8f. Location (Str	eet and Number or Rura	al Route Number
	Dire	erti	4 Homicide	building, etc. (Speci	fy)	out, lastery, office		City or Town	, State)	ir riodio rvambol,
Hospita	within 24 hours after To the Funeral Directory completely filled in by	edical C	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Examination	sician: To the best of my kno ner: On the basis of examina	owledge, deat ation and/or in	n occurred at the tin	ne, date and place, a pinion, death occurre	nd due to the ca	use(s) and manner as s	tated.
d	thin ;	Med	29b. Signature and title of certifier	and manner stated.		29c. License				
Ţ	. ₹ 5 8		The state of the s	- () 1		290. License	a municial	. 29	d. Date signed (Month,	14
	y		1 when a	wy. /sten	era /	D-	14865	/	HRIL 13	-2008
	nes		30. Name and address of person who can Robustiano J.				al Avenue,	Cumber	land, MD 2	1502
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa						

Certificate of Death

2. Date of Death

Month

Day

8

Year

14. Race - American Indian

cab

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Dav

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

Year

Month

black

Black, White, etc.

Specify:

2008

2:00pm

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

20901

Ethiopia

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sepanich RSM MD

1. Decedent's Name (First, Middle, Last)

Ahmed

Ali

Physician

Barbara Supanich, RSM MD 1500 Forest Glen Rd. Silver Spring, Md. 20910

D 0065485

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Registrar

State

completely

within 24

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 2 1 2008

Division or Vital Records, P.O. Box 68760, B	Hospital or Attending Physician: The law requires that the death certificate be executed Hospital or Attending Physician and Ph	uju al-transit
ords,	The law requires the	r, page 2 should be do

		1 - State Amended #7pe			B rtificate of L		2. Date of Dea	Reg. No.	0813	Time of Death
Physici			Bruce Andre	01.10			Month April	D - 6	2008	8:00A M
/Medio Examin		4a. Facility Name (If not institution, give		EWS	4b. City, Town, or	Location of Death		4c. County		
Examin	ie.	14040 Eswo	rthy Road		German	town		Montgo	omery	
uneral		5. Social Security Number 6. S	ex 7. Age ((In yrs. last birthd	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth	n V. Year)	9. Birthplace _Country)	(State or Foreig
rector		459-38-2023	X M 2□ F	78 79 Yrs	s. Menale Baye	110010	Feb. 19	, 1929	Texas	
w c		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or	r Location				10d. I	nside City Limit
fied a	tor	Maryland Montgome	erv	Germa	ntown				1	l∐Yes 2 X ∏N
or 28a e noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
23a c		14040 Esworthy	Road		2087				.S.A.	
tems er m	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	rer in U.S.	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	e - American Ir k, White, etc.	ndian,
, or l	by F	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	1 TyYes 2 No If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 【X No	Specify:		Specify.	White	2
atura cal Ey		15. Decedent's Ed	lucation	16a. De	ecedent's Usual Occup	ation		16b. Kind of Bu	siness/Industr	у
an "n Medi	Completed	(Specify only highest gra	College (1-4or 5+)) (G	Rive kind of work done of fe. DO NOT use retired	unng most or worl ()	ang			
t, the	Con		4	Gov	ernment Re					Corp.
even even	Be	17. Father's Name (First, Middle, Last) Donald Kennedy	Andrews.	Sr.		18. Mother's Nam		Livsey	e)	
narke	ဥ	Donald Kennedy 19a. Informant's Name/Relationship (lailing Address (Street	Ruby			State Zin Con	ne)
27 Is r traur		Sue W. Andrews -			40 Esworth			own, Ma		
other		20a. Method of Disposition		20b. Place of Di	isposition (Name of crematory or other place	201	Date	20c. Location -	City or Town,	State
rt: #		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Specif			litan Crem	1	4/18/08	Alexand:	ria. Vi	irginia
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		21. Signature of Funeral Service Licer	See 2 Clu		22. Name and Addres Molesworth 26401 Ridg					20872
-9		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the						App	proximate erval Between
sician		Immediate Cause (Final disease or condition								
			a Metor	tatic	Pancreatic	Concer			ĕ	set and Death
		resulting in death)	a. Due to (or as a c	consequence of):	Poncreatic	Concer			8	month
	J.		b			Concer			8	ment h
miner	miner		b	consequence of):		Concer			é	mently
miner	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c			- Concer			ĕ	ment
miner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a c	consequence of):		Concer			8	b menth
g physician and as the burial-transit	ledical	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence of):		Concer			2	set and beauti
g physician and as the burial-transit	ledical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b	consequence of): consequence of): f pregnancy □Fetal death	: : : 3 □Ectopic pregnancy			23d. Dat	te of delivery	month
g physician and as the burial-transit	sician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence of): consequence of): f pregnancy □Fetal death					te of delivery	month
g physician and as the burial-transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No	b. Due to (or as a decomposition of the control of	consequence of): consequence of): f pregnancy Fetal death me of death	3 □Ectopic pregnanc, 5 □ Other (specify) □	1	23e. Did to		te of delivery	y Year
g physician and as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as a decomposition of the control of	consequence of): consequence of): f pregnancy Fetal death me of death	3 □Ectopic pregnanc, 5 □ Other (specify) □	1	23e. Did to	Mo obacco use contr	te of delivery nth Day	Year
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eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	consequence of): consequence of): f pregnancy	3 Ectopic pregnancy 5 Other (specify) The underlying cause give atient 3 DDA Other atient 4 DDA Other	en in Part I. 26. Place of Dea er: 4□ Nursing H y at k? Yes 2□No me, date and place ppinion, death occu	24a. Was autop performent of Yes th (Check only of the Check on the the the the the the the the the the	obacco use control fes 2 No an 24b. V ssy rmed? 2 No dence 6 □ Oth- now injury occurr Street and Numb vn, State) cause(s) and ma date and place, 29d. Date signed	te of delivery nth Day ribute to the ca 3 Probably Were autopsy prior to comple death? In Yes 2 Per (Specify) red er or Rural Ro anner as stated and due to the	year year ause of death? definition of cause

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician April 200⁸ 11:45 pm Dorothy Jane Billet /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Westminster 837 Wisteria Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 07 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Hours Months 1928 1 □ M 2 1 F 214-26-0108 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2√2 No Director Carroll Westminster MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 should be filed within 72 hours after death with nand Mental Hygiene.
Is marked other than "natural", or Items 23a or ? 21157 USA 837 Wisteria Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Williams William Gill 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s f Health ar tem 27 is 837 Wisteria Drive Westminster, MD 21157 Charles M. Billet/husband Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery 04/17/2008 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee Pritts Funeral Home and Chapel, P.A. 21157 al 412 Washington Road Westminster, MD 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician - Wo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death Division or Vital Records, P.O. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? res 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred al or Attending F after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 No neral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) WJL 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

APR 15

2008

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

	1	For State Registrar	Otate of Wit	ar yrarre		rtificate of		TIG WICHE		. No. 2001	3 14452
Physician	1	1. Decedent's Name (First, Middle, La.	st) Bo	01	·		-		e of Death	Day Year	3. Time of Death
/Medica Examine	-	4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	r Location of	Death		4c. County of De	ath
A service of the serv	2.0	Howard County Gen	eral Hospi	Ltal		Columb				Howard	
Funeral Director		220 72 8413	Sex 7. Ag	e (In yrs. Ia 65	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mc	e of Birth onth, Day, Y 1 17,	'ear) (irthplace <i>(Stat</i> e or Foreign Country) D
and t	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
Maryl f sho	5	MD Howard	1	בו ז	licott	City					1 ∐Yes 2 XNo
r 28a	22	10e. Street and Number		1111	LICOLL	10f. Zip Code			10g	. Citizen of What (Country?
ifter death with the Mar r items 23a or 28a-f sl iner must be notified	2	11735 Homewood Rd				210	42			United	States
ems :	2	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Decedent of H	ispanic Orig	in? (Specify Ye Puerto Rican,	s or No- etc.)	14. Race - An Black, Wh	
urs a	2	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2	No		1 □ Yes 2 1 No	Specify:			Specify:	lack
ed within 72 horygiene. ner than "natur. it, the Medical E		15. Decedent's Ed (Specify only highest gra	ducation ade completed)		(Give	dent's Usual Occup	during most	of working	16	b. Kind of Busines	s/Industry
within ene. than a		Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT use retired	,			Saiontif	ic American
filed Hygie		unknown 17. Father's Name (First, Middle, Last,			ASSE	mbly Worl		's Name (First,		iden Surname)	IC Allerican
Mental H arked otl atic ever		Daniel Boone				:	Glori	a Cunni	ngham	1	
shou and M s mar umat	1	19a. Informant's Name/Relationship (Type. Print)		1	ng Address (Street					. , ,
and 2 ealth a n 27 ls		Marni L. McNeese/	Friend			Lasting 1		Way Col	lumbia	, MD 210	45
Pages 1 and of He		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			-	esition (Name of matory or other place Chapel (Date 1-24-200		c. Location - City o	
permit. I Departm Importar any Inju		21. Signature of Funeral Service Licer		M0104	14	2. Name and Addre	ss of Facility	Harry H	I. Wit	zke's Fa	mily FH Inc.
- Water	1	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that causer	the death.							, MD 21043 Approximate
Physician		Immediate Cause (Final disease or condition			Interval Between Onset and Death						
/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	ight /	ren	rephuc	- H	earton	-61
executed in and rial-transit	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence of):	rest /	<	DISE	750	_	
ifficate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of):	pett	527				
ificate be g physicia as the bu			d		7						
attendin for use	SICIALIVIN	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	⊒Ectopic pregnancy ☑ Other <i>(specify)</i> _	/			23d. Date of d Month	lelivery Day Year
that the ned by the detach		Part II. Other significant conditions	_	- 1	_		en in Part I.	23	e. Did toba	cco use contribute	to the cause of death?
w requires that the dispersion is been signed by the should be detached	2	MENTAL.	RETTA	21	471	'on			1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown
sertificate has been signe lirector, page 2 should be on the completed by	nipiere							_	a. Was an autopsy performe Yes 2	prior t	
cian: sertifica sector, p		25. Was case referred to medical					26. Place	of Death (Chec			75 212190
hysici this ce al direc	2	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Dispatie	ent 2 □ E	R/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nur	sing Home 5	Residen	ce 6 □Other (Sp	pecify)
th.: After the function of		27. Manner of Death 1 12 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		28b. Time o Injury	Wor	yat k? Yes 2∐N		escribe how	injury occurred	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		3 Suicide 6 Could not be determined				reet, factory, office		28f. Loc Cit	cation (Stre y or Town,	et and Number or State)	Rural Route Number,
o the Hospita ithin 24 hours o the Funera ompletely fille			nysician: To the best miner: On the basis o and manner st	f examinati							
To th within To th comp	INC	29b. Signature and title of certifier	y ms			29c. Licens	e number	37	290	I. Date signed (Mo	nth, Day, Year)
Sec.	-	30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print) KZ	NN C	ETH	C76	mi	1/201.
State Registrar		31. Date filed (Month, Day, Year)	2008 32. Registr	ar's Signati	ure	foods	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 04-16-2008 1:02 Рм PEARL CECELIA BUTLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery WASHINGTON ADVENTIST HOSPITAL Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2/EX Months Days Hours Min. 59 10-29-1948 Wash..DC 578-64-1453 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show be notified at 1- Yes 2 No Director Suitland Marvland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20746 USA Funeral 3816 Walls Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 TNo Specify Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Solomon E. Mack Mildred T. Dunmore 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie D. Woods-Butler/daughter 3816 Walls Lane Suitland, Maryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Nat'l Harmony Mem. Pk. 04-25-2008 4 □ Donation 5 □ Other (Specify) Landover, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mary Hedgman MO1374 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons vuence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes No
9 Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 24a. Was an autopsy has e 2 certificate ha perform 2/2 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA P repatient this funeral 28a. Date of Injury (Month, Day Year) 27. Marrier of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Injury 1 a ural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 / Accident 6 Could not be 3□ Suicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the 1

the Maryland

Medical Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month,

determined

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date sighed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 14,13,19 bper Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** VIRGINIA ZINER BLACK 3:05 A M 04-17-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12–17–1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 578-22-5205 85 Director Newark, N.J. Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Director Prince George's Camp Springs Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20747 5400 Manchester Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
White Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 1 No 1 Never Married 2 Married Specify: Black 'natural", or 1 ☐ Yes 2 ₺ No Saltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 12th Entrepreur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Piskadlo Martin Ziner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 Manchester Dr. Camp Springs, MD 20747 **20746** Department of Health Important: If item 27 any Injury or other tr Donald E. Black/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04-21-2008 | Suitland, Maryland Cedar Hill Cemetery 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility > Mary Tedoman Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final myocardial infaction Acute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? gasko entestinal bleeding ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Chronic obstructive arrway disease 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 autopsy performed? 2 No 1□ Yes 2 100 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dimpatient 2 ER/Outpatient 3 DOA 1 Tes Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD MD0057800 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5711 Sasves avenue # Riverdal, MD 20737 ASHRAF MUHAMMAD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 K front Registrar APR 2 1 2008 DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Maryl		artmen rtificat				F	Reg. No.	2008	1455
	Physici /Medi		1. Decedent's Name <i>(First, Middl</i> e, Las <i>t)</i> Maria	С.	Boiss	e				2 Date of Dea April 1		08 Year	3. Time of Death 6:13 A M
	Examir		4a. Facility Name (If not institution, give the 103 Kerby Hill Road	street and number)		_	Town, or Vashir	Location of	Death			County of Deat Prince G	
	Funeral Director		5. Social Security Number 6. Set 578–42–6692	7. Age (In)	vrs. last birthday) O Yrs.	II Under Months		If Under 2	4 Hrs. Min.	8. Date of Birt (Month, Day NOV 22,		0.51	thplace (State or Foreign buntry) Mexico
	h the Maryland r 28a-f ehow	irector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georg 10e. Street and Number		Ft. Wash		Code				10g. Citiz	zen of What Co	10d. Inside City Limits 1 ☐ Yes 2√√√√No puntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural', or itema 23s or 28e-1 ehow any injury or other traumatic event, the Marifical Examiner must be notified at Ance.	by Funeral Directo	103 Kerby Hill Road 11. Marital Status 1 Never Married 2 Married 30X Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:				spanic Origi n, Mexican, Specify:		cify Yes or No- Rican, etc.)		Mexico 14. Race - Ame Black, White Specify: H	
121215-0036	iled within 72 hou Hygiene. ther then "nature nt, the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usua kind of wo DO NOT us tologis	rk done d se retired,	uring most (g (First, Middle,	Beau	nd of Business/ ity Salon	Andustry
Maryland	should be to marked or matic eve	To Be	Jose Garnica 19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Maili	ng Address	(Street a	A	milia	Fie	rro	r Town, State, 2	Zin Code)
re, Ma	Health ar Health ar tem 27 Is other trau		Barbara A. Tolarski / F	ersonal Rep.		W. Roll	ing W	lood Co	urt H		Flor	ida 3444 cation - City or	42
Baltimore,	mit. Pages partment of portent: If I y injury or CE.		1 ☐ Burial 2XXCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	K	alas Crem	atory		O ₄	4/18/: Geor		_	water, M Tuneral H	
מ	80 E 8 8		23a. Part . Enter the disease, or complishock, or heart failure. List only or	IA CAUSA ON AACH IINA	eath. Do not ent	ter the mod	e ol dying	, such as c	ardiac or			and 20	745 Approximate Interval Between Onset and Death
8/60,	Physician /Medical Examiner up prize per prize p	licai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con		MU	VA L 1/174	- 1) 1	130	ase			
P.O. Box 6	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pr					2	23d. Date of del Month	livery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying c	ause give	n in Part I.		23e. Did to			o the cause of death?
Division of Vital Records,	ilcian: The law re certificete has bee rector, page 2 sho	Completed	25. Was case referred to medical							1 ☐ Yes	sy rmed? XX No	prior to death?	utopsy findings available completion of cause of
IO IO IOI	ding Phys h. After this funeral di	ation: To Be	avaminar?	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year			8c. Injury Work	4 🗆 Nurs	sing Hom	(Check only only only only only only only only	lence 6	S □Other (Spe y occurred	cify)
DIVIS	tal or Attencis after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, lactory	, office		2	8I. Location (S City or Tow			ural Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medicai ((Check only 2 Medical Examilione)	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, deat ination and/or in	vestigation,	in my op	inion, death	place, ai occurre	nd due to the d d at the time, d	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	Tot Tot Com	M	29b. Signature and title of certifier			I	License	POd unuper	174			e signed (Mont	
. ((6)		30. Nam an address of person who co	7801 Old Brand	ch Avenue		Clin	ton, Ma	rylar	nd 2073	35		
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 8 2008	32. Registrar's Si	gnature								

Physici	ian	1 - For State Registrar 1. Decedent's Name (First, Middle, La	D		artment of F rtificate of	Death		a. No.	Year 3. Time of Death	
/Medic Examir		4a. Facility Name (If not institution, giv HARFORD MEMORIA	by Street and number			or Location of Death	<i>4 1</i>	4c. County of Death HARFORD		
Funeral Director		5. Social Security Number 216–48–1773 6. S 2usual Residence of Decedent	M	rs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) ULY 27,	^(ear) 1948	Birthplace (State or Foreit Country) MARYLAND	
the Marylan 28a-f ehow	ector	10a. State 10b. County MARYLAND CEX 10e. Street and Number	CIL 10c. 0	City, Town or Lo	PERR	YVILLE		0	10d. Inside City Limit 1 🎇 Yes 2 🗆 N	
th with	al Di	18 CHESAPEAKE	LANDING DRIVI	E	10f. Zip Code 219	03	100	g. Citizen of W US		
is 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiane. If the att and Mental Hygiane. If marked other than "natural", or items 23e or 28e-f ehow other traumatic event, the Madical Examinar must be multied at	t by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ofy Yes or No- ican, etc.)	14. Race	- American Indian, c, White, etc.	
ithin 72 ha ne. nem "netu Medicel	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of working d)	9	Sb. Kind of Bus	siness/Industry	
ould be filed w I Mental Hygier Narked other th Natic event, the	To Be Cor	17. Father's Name (First, Middle, Last) CLARENCE MILLER		DI	PW SUPERV	ISOR 18. Mother's Name ELLEN BE			OVERNMENT •)	
and 2 sho lath and ! 127 ie ma er trauma		19a. Informant's Name/Relationship (-	and Number or Rural E LANDING		,	State, Zip Code) LLE, MD 21903	
permit. Pages 1 end Department of Health Importent: If item 27 any Injury or other tr once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif) 21. Signature of Funeral Service Licen	Removal from State	Place of Dispo cemetery, crer ERKLEY (sition (Name of natory or other place EMETERY Name and Address	_{сө)} Да Дини	te 20 /08	DARLIN	City or Town, State	
Medical Asician and Asician and Be burial-transit	cal Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse c. Due to (or as a conse d. Curr	rosele enteus	retie a we car	ardiovas Deovasus Deseas	eular de larde	diseas	2	
ine law requires that the death centilicate the has been signed by the attending phy lage 2 should be detached for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preging 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3□	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year	
been signed t	5	Part II. Dther significant conditions or	ontributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.		. /	oute to the cause of death? B Probably 4 Unknow	
	e Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performer	d2 de	ere autopsy findings availab or to completion of cause of ath? Yes 2 No	
S 25	ToB	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	t 3□ DOA Othe			e 6 □Other	(Specify)	
After	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury At I	28b. Time of Injury		yat 28 (? Yes 2 □ No	d. Describe how	injury occurred		
within 24 hours after death		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	building, etc. (Spec	owledge death	occurred at the tim	e date and place an	d due to the caus	State)		
within 2 To the complet		29b. Signature and title of certifier	Geor, MD.		29c. License				(Month, Day, Year)	
10		30. Name and address of person which is the second of the	o pleted cause of death (Ite	UNION	AVE 1	LAURE de	GRACE	MD	21078	

			1 - For State of N	Maryland / Dep	ertificate of			giene Reg. No. 2008	14457		
÷	Dhyaiai		Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death		
	Physici /Medic		Bianca Christine Curvey				1 -	12, 2008	12:40a ^M		
	Examin	er	4a. Facility Name (If not institution, give street and numbe Southern Maryland Hospital			or Location of Death	1	4c. County of Death	200		
	Funeral			Age (In yrs. last birthday		Clinton Prince Geo: Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthpla Country					
μ	Funeral Director		None 1□M 2XF	Hours Min.	(Month, Da		aryland				
	pu ,		Usual Residence of Decedent	10c. City, Town or L	continu						
	faryla shov	ō	10a. State 10b. County					1	0d. Inside City Limits 1 ☐ Yes 2 No		
	the N 28a-1	rect	Maryland Charles 10e. Street and Number	Nanjen	10f. Zip Code			10g. Citizen of What Coun			
	h with	Funeral Directo	4670 Port Tobacco Road			662		U.S.A.	•		
	ems 2	ner	11. Marital Status 12. Was Deceder Armed Force:	nt Ever in U.S. 13.	. Was Decedent of I	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No	14. Race - Americ Black, White,			
9	s after , or its	by Fu	1 Never Married 2 Married 1 ∏ Yes 2 If Yes. Give	X №	1 ☐ Yes 2 ☐ No		o riioan, oto.,	Consitu			
Ö	hours tural"	q pe	3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education		edent's Usual Occu			16b. Kind of Business/Ind			
5	nin 72 n "na Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o	(Give	e kind of work done DO NOT use retire	during most of wor ed)	king	TOD. KING OF DOGINESS/INC	lustry		
212	d with giene er tha	Completed	O College (1-40		ant			None			
n	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show atte event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)					Maiden Surname)			
<u>√</u>	should be filed within and Mental Hygiene. s marked other than umatic event, the M	မ	Vigil Curvey	405.14-5	Company (Our or		Leonard				
Maryland 21215-0036	d 2 d 2 d 2 d 3 d 4 d 4 d 4 d 4 d 4 d 4 d 4 d 4 d 4		19a. Informant's Name/Relationship (Type. Print) Kelly L. Curvey Mothe					er, City or Town, State, Zip Dy, Maryland	20662		
ē,	s 1 and strength Health Item 27 other tr		20a. Method of Disposition	20b. Place of Disp	osition (Name of	acco na.,	Date	20c. Location - City or To			
altimore,	Page: nent o nt: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	e Metropol	Litan Fund	^{ce/} April 1 eral:Serv	6, 2008 ice	Alexandria	Virginia		
alti	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Signature of Funeral Service Licensee		22. Name and Addre	ess of Facility	- 17				
00	90 E # 9	11 1/	prolandling		4270 Haw		.,_India	an Head, Md.	20640		
		8	23a. Part1. Enter the dise se, or complications that edus shock, or heart familie. List only one cause on each	ed the death. Do not er line.	nter the mode of dyi	ing, such as cardiac	445	1 1	Approximate Interval Between Onset and Death		
le le	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	1 retern	1 into	int -	Jun	naturby onviable			
	Examiner	ner	Due to (or a	as a consequence of):			N	onviable.			
	1		Sequentially list conditions, if any, leading to immediate Due to (or a course). Extra I lead this course is the course of the c	as a consequence of):							
	ocuted nd rransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
20,	ate be executed hysician and the burial-transit										
68760	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical	d								
Box	death certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes					23d. Date of delive	NTV		
	death e atte	icla	in the past 12 months?	at time of death 5	□Ectopic pregnand □ Other (specify) _	у			Day Year		
J.	at the de by the a tached	hys	9 ☐ Unknown 9 ☐ Unknown								
_	uires tha signed I d be det	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause gi	ven in Part I.		obacco use contribute to the			
ecords,	w requir been si should	Completed					10,	Yes 2M2No 3∐Prob	ably 4 □Unknown		
T E	The faw cate has to page 2 s	mple.					24a. Was	osy prior to cor	psy findings available npletion of cause of		
_			25. Was case referred to medical				1□ Yes	2 ☑ No 1 ☐ Yes	2 12 No		
	Physiclan: this certificatal director, I	o Be	examiner? 1 Yes 2 No Hospital: 1 Finpa	tient 2 ☐ ER/Outpatie	ent 3 DOA Oth	26. Place of Dea her: 4☐ Nursing H		<i>ine)</i> dence 6 □Other <i>(Specif</i> i	<i>a</i>		
	ding Phys h. After this funeral dir	\vdash	27. Manner of Death 28a. Date of In	jury 28b. Time o				now injury occurred	7		
SIO	Attending r death. ector: After by the funer	atio	2 Accident investigation	a, , , a, , , , , , , , , , , , , , , ,		Yes 2 No					
UIVISION	il or Attendation after death	Certification:	determined 200. Place of I	njury - At home, farm, st etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
			29a. Certifier 1 Certifying Physician: To the bes	st of my knowledge, dea	th occurred at the t	ime date and place	and due to the	cause(s) and manner as et	hated		
	e Hos 24 h e Fun letely	Medical	(Check only 2 Medical Examiner: On the basis and manner:	of examination and/or in	nvestigation, in my	opinion, death occu	rred at the time,	date and place, and due to	the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Month,	Day, Year)		
)			Meena Mant			54760		4/14/08			
+	3)		30. Name and address of person who completed cause of MEENA ANANT 1503 Su 31. Date filed (Month, Day, Year) APR 1 8 2008	death (Item 23a) (Type RRATTS RO	Print) AD CLIN	TON MD	20735				
	Sta Registr	- "	31. Date filed (Month, Day, Year) 32. Rosis	trar's Signature	parte						

			Please Type or Print in E State of Marylan					•	
		•	1 - For State Registrar		rtificate of			Reg. No. 🤈 🔒 🔒 🖺	11.1.58
			Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
	Physici: /Medic		Robert Howard Carter				April	11 2008	10:25 a ^M
	Examin		4a. Facility Name (If not institution, give street and number) Future Care of Chesapeake		4b. City, Town, o	r Location of Death .d		4c. County of Dea	
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H						h 9. Bir y, Year) Co	thplace (State or Foreign
	Director		216-24-4557	Yrs.	Monaro Bayo	1,0010	Nov 1	8 1929	MD
ryland	ital Hygiene. A other than "natural", or tems 23a or 28a-f show event, the Medical Examiner must be notified at		10a. State 10b. County 10c. City	y, Town or Lo					10d. Inside City Limits
e Ma	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	MD Carroll	Mt.					1 res 2 No
with	a or 2	Dir	10e. Street and Number 713 Midway Avenue		10f. Zip Code			10g. Citizen of What Co	ountry :
leath	ns 23 musi	era	11. Marital Status 12. Was Decedent Ever in U.	.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecity Yes or No		erican Indian,
o after d	or Iter		Armed Forces?				Rićan, etc.)		te, etc.
Z I 5-0030 thin 72 hours af	ral", c Exan	d by	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:		1 □ Yes 2 🛣 No	Specify:			White
12 h	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	nation during most of worl	king	16b. Kind of Business Ironworker	
d withir	than	omo	Elementary/Secondary (0-12) College (1-4or 5+)		Ironworke			#16	
illed o	I Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)				e (First, Middle,	Maiden Surname)	
yland ould be file	Aenta rked tic ev	To B	Walter Lee Carter			France	s Glowin	nski	
Mary d 2 sho	and le ls ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Town, State,	Zip Code)
6, 2	m 27 her tr		Michael Carter/son			Riderwoo		21139	
IOFE	or of		1 ☐ Burial 2 XCremation 3 ☐ Removal from State	cemetery, crer	osition (Name of matory or other place	,	572008	20c. Location - City or	
SAITIMON Dermit, Pages	intmer intant: injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		Cremation			Hampstead	
De la	Depar Impor any Ir once.		Jim Jim Jim Jim Jim Jim Jim Jim Jim Jim] -]	Pritts Fu	ineral Hor	me and (Chapel, P.A minster, M	• 01157
			23a. Part 1. Enter the disease, or coordinations that caused the death shock, or heart failure. List only one cause on each line.						D 21157 Approximate Interval Between
Pi	nysician		Immediate Cause (Final disease or condition	inon		disec			Onset and Death
1	Medical		resulting in death) Due to (or as a consequence of the consequence of	uence of):	,,,	10000			0
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ted	ısit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	derice oi):					
J, executed	n and al-tra	Examiner	that initiated events resulting in death) Last c Due to (or as a consequence of the consequence of	uence of):					
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death certificate be	ng ph	Physician/Medica	IF FEMALE:						
ath cer	ttendi or use	ian/I	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Feta	ldeath 3□	□Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
ا ا ا ا ا ا	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	eath 5L	Other (specify) _				,
law requires that the	ed by detac		Part II. Other significant conditions contributing to death but not rest	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
rds quires	n sign	d by					1 🗆 1	Yes 2 No 3 P	robably 4 DUnknown
ecords law requires	ss bee 2 sho	Completed					24a. Was		utopsy findings available completion of cause of
F a	ate ha	Com					perfo	rmed? death?	
VIICALI Iclan:	ertific ector,	Be (25. Was case referred to medical examiner?		044	26. Place of Dea	th (Check only o	one)	
Phys	this cral dire	. To	1 Yes 2 Hospital: 1 Inpatient 2 ☐ 27. Manner Ceath	ER/Outpatier 28b. Time o		4 Nursing H		dence 6 Other (Spe	ecify)
STOR	th. : After	tion	1 □ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Wor	rk? Yes 2∐No	200. 2000.120	now injury occurred	
VISI Atter	r deat ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At ho building, etc. (Specif	ome, farm, str	reet, factory, office		28f. Location (a	Street and Number or F	Rural Route Number,
<u>ة</u> ב	s afte al Dir ed in l	Certification:	Hornicide building, etc. (apecin	77			City of 10	wii, State)	
DIVISION OF VICA To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Physician: To the best of my kno (Check only one) 4 Medical Examiner: On the basis of examinal and manner stated.						
To th	withir Comp	Me	29b. Signature and title of certifier		29c. Licens	se number	25	29d. Date signed (Mon	oth, Day, Year)
V	125		30. Name and address of person who completed cause of death (Item	n 23a) (Type,	Print) _1/	10010	7/	1//	11 2/100
	5	(Jenni Fer Xiodinger 8601 31. Date filed (Month, Day, Year) 32. Registrar's Signa	Vete,	ranstitu	Vy M.	llersi	ille N	(D) 01100
	Sta Registr		APR 1 5 2008	K.	Coaste				
DHMH	I 17 Rev 1/2	001	/11 Ft 2. 0 12000	6					

Physician /Medical Examiner

attending physician and for use as the burial-trar

signed by the aid be detached f

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

Director

Funeral

Completed by

Be

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Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

State

death with the Maryland

filed within 72 hours after Hygiene.

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Pages 1 permit. Pages Department of Important: If it any Injury or o

"natural"

item 27 is marked other than "natu other traumatic event, the Medical

21215-0036

Maryland

Baltimore,

Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

28a. Date of Injury (Month, Day Year)

28b. Time of

28d. Describe how injury occurred

27. Manner of Death T Natural
2 ☐ Accident 3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D41723

29d. Date signed (Month, Day, Year) APRIL 6, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTADOSS RAJASINGH M.D.

31. Date filed (Month, Day, Year) APR 1 0 2008 522 IDLEWILD AVE. EASTON, MD 21601

Registrar DHMH 17 Rev 1/2001

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ours after death.

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filled in by the fu

within 24 hours a

4/1	14/08,	A1	legany Co. State of Maryland / Department of State State of Maryland / Cell			ne	14450		
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) GOLDIE E CARTWRIGHT 4a. Facility Name (If not institution, give street and number) ALLEGANY CO. NURSING & REHAB CTR.	4b. City, Town, or Location of Death CUMBERLAND		Day Year 10, 2008 4c. County of Death ALLEGAN			
	Funeral Director		5. Social Security Number 220–26–0249 Usual Residence of Decedent Co. Notice 10 (A. Sex 1) (A. Sex 1) (A. Sex 1) (A. Sex 1) (A. Sex 2) (A. S	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry) RYLAND		
	he Maryland 8a-f show otified at	Director	10a. State 10b. County 10c. City, Town or Lo	ĪN			10d. Inside City Limits 1 ☐ Yes 2 XNo		
	s 23a or 2 nust be n		20100 HELENA DRIVE 11 Marital Status 12. Was Decedent Ever in U.S. 13.	10f. Zip Code 21555		U.S.A. 14. Race - Amer			
9800	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2127 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecity Yes of No- Rican, etc.)	Black, White	, etc.		
21215-0036	T In	Completed	(Specify only highest grade completed) (Give life. Is Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) MEMAKER	b. Kind of Business/Industry HOME				
Maryland ;	be filed ntal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) JACOB STEVEY	UNKNOW	N	ITOPIE irst, Middle, Maiden Surname)			
	Health tem 27 is		WALTER CARTWRIGHT / SON 1017	ng Address (Street and Number or Rura SANDSTONE DRIVE, Consistion (Name of matory or other place)	JEFFERSON		IANA 47130		
Baltimore,	permit. Pages Department of I Important: If ite any Injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	EMORIAL CEM. 04/14 2. Name and Address of Facility UPCHURCH FUNERAL		CUMBERLA	MD, MD		
	Physician /Medical Examiner		23a. Part1. Enter the discase, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	202 GREENE STREET	or respiratory arrest,	AND, MD	Approximate Interval Between Onset and Death		
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):						
.O. Box 68	that the death certificate led by the attending physidetached for use as the b	Physician/Medi		⊒Ectopic pregnancy ⊒ Other (specify)					
ords, P.	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the un	23e. Did tobace	a. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknow				
or Vital Record	The law ate has b page 2 sh	Completed			24a. Was an autopsy performed performed 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?				
r Vit	ys dir	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death		e 6 □Other (Spec	ify)		
	ding h. After funel		27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	f 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred			
Division	i di di	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,		
	ne Hospital n 24 hours a ne Funeral oletely filled	Medical	29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)		
	vithi Vithi C. Com	Ň	29b. Signature and title of certifier Polycott and J. Barrer	29c. License number D - 1 4665	29d.	Date signed (Month	, Day, Year)		
	nes		30 Name and address of person who completed cause of death (Item 23a) (Type,	Memorial Ave	Cumbe	rland M	D 21507		
	Sta Registr	_	31. Date filed (Month PR 1 4 2008 3 Registrar's Signature	arti	* 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #4c. Per Phys. PGC4-18-08Cr 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Montgomer Prince Co Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 □XF 56 129-52-2508 Director 1951 Grenada Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. "naturel", or Iteme 23e or 28e-f ehow int: If item 27 is marked other than "naturel", or Iteme 23e or 28e-f ehow 10c. City, Town or Location New Carrollton 10a. State 10b. County 10d. Inside City Limits r than "naturel", or Iteme 23e or 28e-f ehov the Medical Examinar must be notified at Prince Georges Maryland 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8200 Carrollton Pkwy 20784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status □Yes 2 XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify: Black Specify: If Yes, Give Year or Dates: Be Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer US Capitol Mortgage 7 is marked other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Monica Hall Michael Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 587 E. 82nd St. Brooklyn, New York 11236 nt of Health a t: If item 27 is r or other tree Christine Daniel sister 20b. Place of Disposition (Name of cometery, crematory scales Place) ark April 19, 200. Location - City or Town, State MD. Nat. Me Laurel, MD 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Importent: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death nmediate Cause (Final Priysician Mocardoo disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, in your cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed lentricular & 4a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed NOUPL 2 No 1 Yes 2 No efter death.

Director: After this certification by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeref I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 00064024

State Registrar

APR 1 8 2008 Security 1 32. Registrar's Si

Janna

30. Name and add ss of person who completed cause of death (Itemy23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

7600 Carroll Ave. Takoma Park, MD

20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Director 209-30-2359 1	Day Year 2008 1:30 P M 4c. County of Death Garrett Sirth Pay, Year) 9. Birthplace (State or Foreign Country) 1940 Pennsylvania 10d. Inside City Limits 1 \(\triangle \text{Yes} 2\text{\text{No}} \) 10g. Citizen of What Country? USA
Carol Joann Cervi O4	22 2008 1:30 P 4c. County of Death Garrett Sirth Pay, Year) 1940 9. Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1 □Yes 2♥No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White
4a. Facility Name (If not institution, give street and number) 87 Wildwood Estates Funeral Director 5. Social Security Number 6. Sex 1 M 2 \mathbb{N} \mathbb{E} 67 Yrs. 4b. City, Town, or Location of Death MCHenry MCHenry MCHenry MCHenry Months Days Hours Min. Min. Months Days Hours Min. Months Days Hours Min. Months Days Hours Min. Months Days Months	4c. County of Death Garrett 9. Birthplace (State or Foreign Country) 1940 Pennsylvania 10d. Inside City Limits 1 □ Yes 2 No 10g. Citizen of What Country? USA 10- 14. Race - American Indian, Black, White, etc. Specify: White
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106. County 106. City, Town of Location 107. Zip Code 108. Was Decedent Ever in U.S. 108. Was Decedent of Hispanic Origin? (Specify Yes or Normal Freedom of Hispanic Origin? (Specify Yes or Normal Fre	1 ☐ Yes 2 ☒ No 10g. Citizen of What Country? USA 10- 14. Race - American Indian, Black, White, etc. Specify: White
MD Garrett McHenry 10e. Street and Number 10f. Zip Code 21541	10g. Citizen of What Country? USA 10- 14. Race - American Indian, Black, White, etc. Specify: White
10e. Street and Number 87 Wildwood Estates 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 11. Was Decedent of Hispanic Origin? (Specify Yes or Note of the property of	USA 14. Race - American Indian, Black, White, etc. Specify: White
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To the first, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) Charles Bevan Vennae Mae Mi	Christmas Tree Shop
Charles Bevan Vennae Mae Mi	le, Maiden Surname)
> of Figure 1	11s
토토토 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Num	ber, City or Town, State, Zip Code)
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Num 19c. Mailing Address (Street and Number or Rural Route Num 87 Wildwood Estates McHenry,	
Eugene E. Cervi / Husband 87 Wildwood Estates McHenry, 20a. Method of Disposition (Name of cermetery, crematory or other place) Date	20c. Location - City or Town, State
1 Burial 2 Comment of Disposition 1 Removal from State 4 Donation 5 Other (Specify) Omega Crematory 0 of the place) 04/26/2008	
4 Donation 5 Other (Specify) Omega Crematory 04/26/2008	Morgantown, WV
20a. Method of Disposition Date Disposition Date Disposition Date	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line.	arrest, Approximate Interval Between
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The second secon	opsy prior to completion of cause of death?
The state of Death (Check only) 25. Was case referred to medical examiner? 26. Place of Death (Check only) Hospital: Other:	2⊿No 1⊔Yes 2□No
24a. Was authorized to medical examiner? 1 St. Was case referred to medical examiner? 1 Yes Ye	
O 1 1 Yes 2 No Pospital 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Res	sidence 6 Other (Specify)
C B B B 1 IZ/Natural 5 □ Pending (Month, Day Year) Injury Work?	e now injury occurred
27. Manner or Death 1	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	(Street and Number or Rural Route Number, own, State)
Solution of the state of the st	
Total Continue of the contin	e cause(s) and manner as stated.
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the control of the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated. 29b. Signature and title of certifier 29c. License number	
29c. License number	29d. Date signed (Month, Day, Year)
	4 1 45 1200
Vaint Round hell 1+26154	
30. Name and address of person who completed cause of qualith (Item 23a) (Type, Print)	-()))))))
Vaint July 1+26,54	V Carry MD

		1- For State of Maryland Registrar	-	artment of h		and M		jiene (08	14463
۰ .	. 🗆	Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death		
Physic /Med		Opal Mae Crowe					Month 04	Day Yeer 18 2008		12:55 P M
Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location o	f Death		4c. Cou	inty of Death	
		Dennett Rd. Manor Nursing Home		Oaklan	d			Gar	rett	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 ☐ M 2 ☒ F 89		If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day 12/10/1	918	Cou	place (State or Foreigr Intry) 1 land
pu ≱		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	nation						10d. Inside City Limits
ILK I 3-UU30 within 72 hours after death with the Maryland ene. then "netural; or items 23a or 28a-f show then "netural or items 23a or 28a-f show	5									1 ☐ Yes 2 ☑ No
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with the	ä	10e. Street and Number		10f. Zip Code	_				of What Cou	intry !
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rs aft	oy F	3 X Widowed 4 Divorced Year or Dates:		1□Yes 2█No	Specify:			Spe	ecify: Wh	ite
hou	ed	15. Decedent's Education	16a. Deced	dent's Usual Occup	pation		1	16b, Kind o	of Business/le	
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Hygin other ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name	(First, Middle,	Maiden Sur	name)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depurtment of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28a-1 show my njury or other treumatic event. The Medical Erantic or must be invitibled at money.	To B	Alvin Dutch Fike			1		lice Fi			
2 sh and is m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street						
and lealth im 27		Connie L. Crowe / Daughter		Mansfiel	Ld Koa		kland,		and ZI on - City or T	
Definition of the popular of the pop		20a. Method of Disposition 20b. Pla cen 20b. Pla cen	netery, cren	natory or other pla				200. Locati	on - City of 1	own, state
men tent: jury				emetery			/2008	Eglo		
permit. Deportr Import any nji		21. Signature of Funeral Service Licensee		. Name and Addre						
905 g	N N	Wan A Millor & 10	32	South S	second	Str	eet Uak	land,	Maryl	Approximate Interval Between
cate be executed cate be executed physician and the burial-transit		resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of the consequence		dem	enti	a	atory			years
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Jing I	<u>-</u>	1 Matural 5 □ Pending (Month, Day Year)	Injury	Wo	rk? / Yes 2 🗆 1		.ou. Describe in	OW IIIJuly Oc	Curred	
of or Attending after death. Director: After din by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, str			_	28f. Location (S City or Tow	treet and Ni n, State)	umber or Rui	ral Route Number,
Hospite 4 hours Funerel	Medicai Ce	29a. Certifier (Check only one) 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and manner stated	edge, death on and/or in	n occurred at the ti	ime, date and opinion, deat	d place, a	and due to the c	ause(s) and late and pla	d manner as ce, and due	stated. to the cause(s)
To the within 2 To the complet	Meo	29b. Signature and title of certifier		29c, Licen	se number			29d. Date si	gned (Month	, Day, Year)
TW TO		Margaret a frem	NO	D:	266	50				
	4	30. Name and address 1 person who completed cause of death (Item 2) Mary and Causer md 13	(3a) (Type,	Print) garrett	higher	dy	call	and,	Md.	21550
S Regis	tate trar	31. Date filed (Month, Day, Year) APR 2 4 2008	re	and s	0	,				

To the Hospital or Attending Physician: The law requires that the death certificate be executed	Baltimore, Maryland 21215-0036
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.

8:25 р.т.

2008

APRIL 15,

ALICE DENNEY

Physicia /Medica Examine

Funeral Director

r death with the Maryland

Registrar			Cei	rtificate of	Death	7		Reg. No	~ U	UÜ		404
1. Decedent's Name (First, Middle, La							2. Date of D Month		av	Year	3. Time o	of Death
Alice Jean Denney							Apri1	1	15, 2008		8:25 P ^M	
a. Facility Name (If not institution, giv		per)		4b. City, Town, o		of Death			_ ′	of Death		
Stella Maris Host Social Security Number 6.8		. Age (In yrs. la	ast hirthday)	Timoniu If Under 1 Year	8. Date of Birth		Baltimore 9. Birthplace (State o.		or Foreign			
	□M XX F	91	Yrs.	Months Days	Hours	Min.	Feb. 1	0 Year 0	917	Com	nsylva	
Jsual Residence of Decedent				I			1					
0a. State 10b. County			;TownorLo 1ver S							1	10d. Inside C	
Maryland Montgom							XX No					
10e. Street and Number 10f. Zip Code 10g. Citizen of What C 3112 Gracefield Road Apt 616 20904 United Sta												
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-												
Armed Forces? If Yes, specify Cuban, Mexican, Puerto										ck, White,		
1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Site No If Yes, Give X 1 ☐ Yes 2 Total Specify: Specify: W										y Whi	lte	
15. Decedent's Ed (Specify only highest gra	ducation ade completed)		(Give	dent's Usual Occup	durina mo	st of work	ina	16b. F	Kind of B	usiness/In	dustry	
Elementary/Secondary (0-12)	College (1-4	or 5+)	`life. L	DO NOT use retired	1)			_		••		
7. Father's Name (First, Middle, Last)	3			Nurse	18 Moth	nor's Name	e (First, Middle			c Hea	alth	
John Loftus							Kilcu		, Garrian	,		
19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street					or Town	State. Zir.	Code)	
Geraldine Roberts	,	iter		Comanche			nold,				,	
Oa. Method of Disposition		20b. Pla		sition (Name of natory or other place			Date			- City or To		
1 ☐ Burial 27 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 1)	Removal from Sta y)	116				4/17/	2008	Ba1	timo	re. M	farvla	nd
4 Donation A Donation Specify Baltimore Crematory 4/17/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, In												
Mihal a Slam 147 Duke of Gloucester St. Annapolis, MD 21401												401
23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	plications that cau	sed the death. h line.	Do not ente	er the mode of dyin	ng, such a	s cardiac	or respiratory	arrest,			Approxima Interval Be	tween
Immediate Cause (Final disease or condition	LUNG	CANCER									Onset and	Death
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F FEMALE: 3b. Was decedent pregnant	23c. If yes, outco	me of pregnan		Ectopic pregnance	.,				23d. Da	te of delive	ery	
in the past 12 months? 1 ☐ Yes 2 X No		nt at time of de		Other (specify)	у				Mo	onth	Day	Year
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art II. Other significant conditions o	ontributing to deat	n but not resul	ting in the un	iderlying cause give	en in Part	L	1				ne cause of	
							1 1	res 2	 □ №	3 Prob	JaDIY 4 X .	Unknown
							24a. Was	psy		prior to cor	psy findings mpletion of c	available cause of
							1 □ Yes	ormed? 2 X IN)	death? 1 ∐Yes	2□No	
5. Was case referred to medical examiner?	Hospital:			Othe	OF:	-	(Check only					
1 ☐ Yes 2 X No 7. Manner of Death	1 ☐ Inp	atient 2 E	R/Outpatien 28b. Time of	1 3 LI DOA	4 L N		me 5 Res 28d. Describe				y) HOSP	<u>ICE</u>
1 Natural 5 Pending 2 Accident investigation	(Month,	Day, Year)	Injury	28c. Injury Work	yan (? Yes 2.⊑		Log. Describe	пом при	ry occurr	- Cu		
3 Suicide 6 Could not be		Injury - At hon	ne, farm, stre	et, factory, office			28f. Location	(Street a	nd Numb	er or Rura	d Route Nur	nber,
4 Homicide	building	, etc. (Specify)					City or To	wn, State	e)			,
9a. Certifier 1X Certifying Ph	ysician: To the be	est of my know	ledge, death	occurred at the tir	ne, date a	and place,	and due to the	e cause(s	s) and m	anner as s	stated.	,
(Check only 2 Medical Exam	niner: On the basi and manner	s or examination stated.	on and/or inv	restigation, in my o	pinion, de	ath occurr	ed at the time	, date an	d place,	and due to	the cause(3)
9b. Signature and title of certifier				29c. License				29d. Da	te signe	d (Month,	Day, Year)	
				1/1/	077	7			1.1	6 1 2		
1:-				109	377	25			- (010	0	
0. Name and address of person who	completed cause	of death (Item :	23a) (Type, F		514	25			- (010	6	-

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APRIL 2008 4:10PM M ROBERT LEWIS DITMAN 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner DORCHESTER MALLARD BAY NURSING & REHAB CAMBRIDGE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JULY 1,1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. MARYLAND 216-28-0981 76 Director Usual Residence of Decedent iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XYes 2 □ No Director CAMBRIDGE DORCHESTER 10e. Street and Number 10g. Citizen of What Country? 21613 USA 116 HIGH ST. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 □ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MILL WORKER STEEL 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOROTHY C. JOHNSON HENRY L. DITMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM W. DITMAN/BROTHER 3787 MARGITS LANE, TRAPPE, MD 21673 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 4/15/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 m. Ostrum C.F.S.F 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** prostate Cancer months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pertension 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed certificate 1∐ Yes 2 1No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Mann of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely 29c. License number 29b. Signature and title of certifier 29d. Date, signed, (Month, Day, Year) 140059973

2+VA

State Registrar 31. Date filed (Month

atticia

30. Name and address of person, who completed cause of death (Item 23a), Type, Print),

Cambridge, MD 21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 04 11 2210 DEREMER /Medical JAMES MARSHALL 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 69 Director 218-34-4884 03/14/1939 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Directo MD Allegany Frostburg 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16315 Harwood Drive 21532 USA Funeral filed within 72 hours after death Hygiene. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Tire and Rubber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, s 1 and 2 should be fil Health and Mental H tem 27 Is marked otl Marshall James Deremer Florence Naomi Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Douglas Deremer / Son 16315 Harwood Drive, Frostburg, Pages 1, ent of Hea. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Injury or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 □ Donation 5 □ Other (Specify) Cumberland Crematory 04/12/2008 Cumberland, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NRUMUNIA disease or condition /Medical resulting in death) (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence of) Examiner death certificate be executed as the burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy P in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ pe 1 | Yes 2 | No 3 | Probably 4 | Donknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 2□No 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🖺 Yes 20 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Injury at Work? Certification: Hospital or Attending 44 hours after death. 1 Naturai 5 Pending investigation Injury ithin 24 hours after death.

the Funeral Director: A
pmpletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

the 2 0

State Registrar

aconer

Name and address of person who completed cause of death (Item 23a) (Type, Print)

925

29b. Signature and title of cert

Gar

31. Date filed (Month, Day, Year

32. Registrar's Signature

Bishop

29c. License number

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Nadine Talbott DeHart 25, 10:00 P.M 2008 March /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Wilson Healthcare Center Gaithersburg If Under 1 Year | If Under 24 Months | Days | Hours | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav 5. Social Security Number 6 Sex **Funeral** Min MARCH 20, 1919 Months 1 □ M 2**X** F 89 VIRGINIA 214-07-4409 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at MONTGOMERY GAITHERSBURG 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 U.S.A. 201 RUSSELL AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: WHITE 9 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental I If Item 27 is marked of or other traumatic eve 1 and 2 should be ETHEL SARGENT CHARLES TALBOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3011 AUBURN VIEW, ELLICOTT CITY, MD WAYNE A. DeHART / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Pages 1 permit. Page Department c Important: If any Injury or once. Injury or CUMBERLAND CREMATORY 03/27/2008 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, MD Upcheuc 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 weeks Adult Failure to Thrive /Medical Due to (or as a consequence of) Examiner Dementia, Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (pries a consequence of) Physician/Medical Examiner law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of) physician as attending IF FEMALE: use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month ò in the past 12 months? 1☐Yes 2☐No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 linknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Osteoporosis 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should l 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Osteoarthritic Esophagitis autopsy 2 No this certificate Gait Disturbance 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D04115 March 26, 2008

cs)

State

Registrar

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 2 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



H. Robert Birschbach, M.D., 201 Russell Avenue, Gaithersburg, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 04 10 2008 2208 HAZEL VIRGINIA DAVIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ALLEGANY MEMORIAL HOSPITAL CIMBERT.AND 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🛛 F 80 Director 218-24-8251 01/21/1928 West Virginia Usual Residence of Decedent 10c. City. Town or Location 10a State 10d. Inside City Limits 10b. County a or 28a-f show be notified at show 1 X Yes 2 □ No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 631 Henderson Avenue 21502 USA Items 23a must Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 1 Never Married 2 Married 5 1 ☐ Yes 2 No Specify: þ White 3 ☑ Widowed 4 ☐ Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry it. Pages 1 and 2 should be filed within 72 realth and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Phillips Hazel ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory B. Davis / Son 1827 Meadow Grove Lane, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If Ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Mem. Gardens 04/15/2008 LaVale, MD any Injury 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician BASAL GANGUA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPEKTENISION Gayantiany liet conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed and resulting in death) Last Due to (or as a consequence of) burial-t attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATHPROSCLIPROSIS Completed peen : has this certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be

	18.00 20	,,,,,	abiy 4 Monkhown
	24a. Was an autopsy performed? 1□ Yes 2 No		psy findings available mpletion of cause of 2 No
26. Place of Death (0	Check only one)		

examiner? 1 ☐ Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

determined

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifiei

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

D19318

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAGARATNAM RANJITHAN M.D. 517 OLDTOWN RD, CUMBERLAND MD 21502

State Registrar

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Certification:

Medical

funeral

After

within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu

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31. Date filed (Month, Day, Year)



Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

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			1. Decedent's Name (First, Middle, L	ast)						2. Date of D Month	eath Day	Yea		3. Time of Death
	Physici		Phyllis Claudine	Donahu	6					April		2008	al	6:00 P M
	/Medio Examir		4a. Facility Name (If not institution, g				4b. City,	Town, or	Location of Deal			County of D	eath	
	Exami	lei	180 Miner Rd.				Grai	ntsv	ille			Garre	tt	
				Sex	7. Age (In yrs.	last birthday)	If Under		If Under 24 Hrs	8. Date of B	irth			ce (State or Foreign
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	Director		220-30-7847 Usuel Residence of Decedent							ADETT O	3, 19.	33 r	lar y	Taila
	and *		10a. State 10b. County		10c. C	ity, Town or Lo	cation						100	d. Inside City Limits
	aryl	5												1 ☐ Yes 2 No
	8a-f	Director	MD Garre	ett	Gra	ntsvill					10. 000		0	
	or 2	j.	10e. Street and Number				10f. Zip	Code			10g. Citi	zen of What	Country	y r
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	d within 72 hours after death with the Maryland place. Then "natural", or items 23s or 28s-f show The Modical Exercitive must be profified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. V	Vas Deced	ent of Hi	spanic Origin? (S	Specify Yes or No Rican, etc.)	lo-	14. Race - A Black, W		
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Maryland	N N N N N N N N N N N N N N N N N N N	ဥ	Ray Wilt			401 44 33		(2)			h Oit	- T Ct	- 7:- 0	2n de l
ā	and and le ma		19a. Informant's Name/Relationship	(Type, Print)			-		and Number or R			r IOWn, Stat	e, zip c	,ode)
	1 and 2 Health tem 27 other tra		James H. Donahue,	/Husband					, Grants			21536		
w	of Hear item othe		20a. Method of Disposition			Place of Dispo cemetery, cren	sition <i>(Nan</i> n <i>atory or o</i>	ne of ther plac	e)	Date	20c. Lo	cation - City	or Tow	n, State
Ĕ	Pages nent of I ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Contro		Gr	antsvi	lle C	emet	erv Apri	il 26, 2	2008	rants	vil	le, MD
≣	permit. Pages Depertment of Important: If I any Injury or o		4 Donation 5 Other (Specify) Grantsville Cemetery April 26, 2008 Grantsvil 21. Signature of Funewal Service Licensee 22. Name and Address of Facility Newman Funeral Homes,											
B	permit. Depertr Imports any inju		1 Par X	louma)				75, Gran			2153		
			23a. Part1. Enter the disease, or co shock, or heart ailure. List of	ferras		1						2100		Approximate
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Car Due to	or as a conse On as (or as a conse	iquence of):	ter	es	F. Dise					Onset and Death
58760,	ficate be executed physicien and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to	(or as a conse	equence of):								
P.O. Box (The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🗖 No 9 □ Unknown	1 ☐ Live	utcome of pregr birth 2 Fet nant at time of nown	tal death 3□	Ectopic pr Other (sp					23d. Date of Month		y Day Year
J	that hed b		Part II. Other significant conditions					ause give	en in Part I.	23e. Did	tobacco u	se contribut	te to the	cause of death?
g	uires I sign Id be	d by	Congective	Hea	A FF	FILLUR	E			10	Yes 2	No 3	Proba	bly 4 □Unknown
Ö	w requ	Completed								04. 146		0.00		
of Vital Records,	elaw hasl	l d									opsy		to com	sy findings available pletion of cause of
I	The la	Ö								1 ☐ Yes	formed?	1 🗆	Yes 2	2 □ No
<u> </u>	ician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place of De	eath (Check only	one)			
>	Physician: this certificaral director,	0	examiner? 1 ☐ Yes 2 X No	Hospital: 1	Inpatient 2	☐ ER/Outpatier	nt 3 DC	Oth	er: 4 🗌 Nursing	Home 5 Re	sidence	6 □Other (5	Specify)	
	Physical Phy	7: T	27. Manner of Death	28a. Date	of Injury	28b. Time of	1 2	28c. Injun Worl	at	28d. Describ	e how injur	y occurred		
<u></u>	E ===	tion	1 Natural 5 Pending 2 Accident investigat		nth, Day Year)	Injury	м		K? Yes 2 ∐No					
Division	il or Attending after death. I Director: After d in by the fune	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	e of Injury - At liding, etc. (Spec		reet, factory	y, office		28t. Location City or 7	(Street an own, State	d Number o)	r Rural	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai C		Physician: To th aminar: On the and ma										
	of the of	Æ	29b. Signature and title of certifier		, /	7	290	c. Licens	e number		29d. Dat	e signed (M	fonth, D	ay, Year)
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		4	30. Name and address of person wh											
			Dr. Robin Bissel				., G	rant	sville,	MD 215	36			
	Sta	ate	31. Date filed (Month, Day, Year)		Registrar's Sigr	nature	Axanth.	and of						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Nina Louise Daniels 7:30 A M April 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 207 Central Ave. Allegany Westernport If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 219-14-5744 1 □ M 250€ 84 Director Nov. 1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notifled at Allegany Westernport Director MD. 1**X** Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 207 Central Ave. 21562 United States Funeral items (12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No o, Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Housework Homemaker 12 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental William L. Ferguson Essie Harshbarger 2 traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Daniels/ husband 207 Central Ave, Westernport, Maryland 21562 of Health 27 Department of Health Important: If item 27 any Injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Philos Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Westernport Maryland 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee a 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician 4 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy perform certificate 2/N No or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 XER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury after death. 2 Accident 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Registrar DHMH 17 Rev 1/2001

Medical

State

(Check only one)

29b. Signature and title of certifia

30. Namerand address of person

Year)

2008

31. Date filed (Month, Day,

o completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

91

umua

29c. License number

29d. Date signed (Month, Day, Year)

amberland

David Junis E	dmur		state of Marylar	nd / Depar		Health an		Hygiene	g. No.	108 144/
Physi Marcal Exa		1. Decedent's Name (First, Mid	dle,Last)		-			2. Date of Deat	h	3. Time of Death
iw hai Exa	mne	David 4a. Facility Name (if not institute)	JUNIS	ber)		Edmunds 4b. City, Town, or	Location of Dea	Month April 15, 2	4c. County of E	2036 hrs
7		1608 Opus Avenue	eni giro on oct and nam			Capitol Hei			Prince Ged	
Funer		5. Social Security Number	6. Sex 7	. Age (In yrs, Ias	st birthday)	If Under 1 Yea				Birthplace (State or organism)
Direct	r	226-60-3347	1 X M 2 F	62	Yrs	Months Day	/s Hours N	03/30/		^{oreign} Halifax, Va.
any		Usual Residence of Decedent 10a. State 10b. Count	v	10c. City. T	Town or Locati	ion				10d. Inside City Limits
br work	<u>.</u>	Md.	P.G.			Heights				1 XYes 2 No
Aarylar 28a-f	Director	10e. Street and Number				10f. Zip Code		10	ng. Citizen of What	Country?
h the A		1608 Opus A	Avenue			20	743		U.S.	A.
th wit	Funeral	11. Marital Status 1 Never Married 2 X		dent Ever in U.S ces?	6. 13. Wa	s Decedent of Hi es, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - A White, e	merican Indian, Black,
ter des	Fu	3 Widowed 4 D	1 Yes ivorced If Yes, Give Year	2 X No	1	Yes 2 X No	specify:		Specify:	Black
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215. se filec stal Hy ked of	Be C							a Marv Sa	·	
21 nould bed Mer	2	19a. Informant's Name/Relation	,		19b. Mailing	Address (Stre	et and Number o	or Rural Route Num	ber, City or Town,	State, Zip Code)
MC straight and 2 straight and 2 straight and 27		Augustine L. E	dmunds/Wife)	4704	Ouarles			gton,D.C.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show.		1 Burial 2 Cremation	on 3 Removal from	State Cr	ematory or oth	ner place)	4,	/23/08	20c. Location - Ci	
Itim it. Pag rtment	5	4 Donation 5 Other 21. Signature of Funeral Service	Specify:	Che		e Cremat				sville,Md
Ba Perm Depa Impo		10.	4	att	$-\begin{vmatrix} 22.11 \\ 10 \end{vmatrix}$	H.S.Was	šhingtor	a & Sons	Co.,Inc.	20019
Physicia		23a. Part I. Enter the disease, of failure. List only one caus	or complications that cau	sed the death. I	Do not enter the	ne mode of dying	, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
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30, te be e	led ic	UNPENDED IF FEMALE:	AMENDED	tooms of around					Tool Bata file	
Sox 68760, death certificate be attending physic	ian/Me	23b. Was decedent pregnant in past 12 months?	the 1 Live birt		2 Fe	tal death 3	Ectopic preg	gnancy	23d. Date of de Month	Day Year
Box e death ce	sici	1 Yes 2 No 9 U		nt at time of dear	th 5 Otl	ner (Specify)				
s, P.O. Be ires that the de ir signed by the	, Phy	Part II. Other significant cond			sulting in the u	nderlying cause	given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
P.O.	d by	Cirrhosis of Liver				<u></u>		1Yes	2 No 3	Probably 4 Unknown
cords, law requir	lete	Chronic Alcoholism						24a. Was a		re autopsy findings available ir to completion of cause of
Rec(E O							perfor 1 Y Yes		th? Yes 2 No
Vital Rec ysician: The l	Be (25. Was case referred to medic examiner?	Hessital				of Death (Che			
n of Vid ding Physic After this		1 ✓ Yes 2 No 27. Manner of Death	28a. Date of	Injury 2	ER/Outpatient 28b. Time of Ir		ury at Work?		Residence 6 🗸	Other: Scene
Division of Vital Records, P.O. Box 6876C the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death.	Certification:		(Month, D	ay,Year)			Yes 2 No			
IVISI or Att after de Direct	iji Ei	3 Suicide 6 Co	not be	of Injury - At hon	me, farm, stree	et, factory, office I	building, etc.	28f. Location (S or Town, S		or Rural Route Number, City
ospital hours ineral		4 Homicide	ermined (Specify)	_		_		10		
Divisior To the Hospital or Attend within 24 hours after death To the Proneral Director:	Medical	(Check only Certifying I	Physician: To the best of aminer:On the basis of	examination and						
L skit 5	Me	29b. Signature and title of certif		ed.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
		my h	mp			O.C.	M.E.		April 16, 200	8
r-		30. Name and address of perso		,		t Raltimore	MD 21201		•	
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Regi			Black.	K A	ares!					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month LARRY FROST 04 2008 10 1020 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F Hours Director 219-44-0832 MAY 22,1946 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Directo MD ALLEGANY CUMBERLAND 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or: 8 W. FIRST STREET 21502 U.S.A. by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: '65-'67 Specify: WHITE 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced er than "natur , the Medical B Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC AUTOMOBILE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY FROST PATRICIA SMITH ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CATHY FROST / WIFE P.O. BOX 793, RIDGELEY, WV 26753 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) M.S.V.C.-ROCKY GAP 04/14/2008 FLINTSTONE, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21502 Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 Days /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year signed by the at d be detached for 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part I]. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has break rector, page 2 s 24a. Was an 1□ Yes Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 20 No 1) Inpatient P 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No To the Hospital or Attenct within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifiei Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Seton De. Cumberland MD 21502 nds M.D. William Lamm 31. Date filed (Month, Day, Year)

Registra

State

APR 1 4 2008

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Ada Catherine Fletcher 1600 P March 25, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Allegany Co. Nursing & Rehab. Ctr. Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 👿 F Months Hours Director 216-74-9071 03/13/1911 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Allegany Flintstone 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12400 W. Wilson Road, NE 21530 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: <u>م</u> 3 Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked ofth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Owen Shipley Clara Virginia Shaffer Joseph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marshall L. Fletcher, Jr. / Son 12400 W. Wilson Road, NE, Flintstone, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Park 03/28/2008 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Spinal re of Funeral Service Licens 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVVS **Physician** Seage Oronany /Medical Due to (or as a consedence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ should be 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 20 No this certificate has Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 1-Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of entitie D33280 March 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 625 Kent Avenue, Cumberland, MD Sunil K. Gupta, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State General & Sparts Registrar MAR 2 7 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 18, 2008 8:00 PM Physician Jonas Luranza Fazenbaker /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Garrett Grantsville Goodwill Mennonite Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year | Min. | May 4, 1910 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Maryland 97 213-01-7157 Director Usual Residence of Decedent deeth with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Meryler Department of Heelth end Mentel Hygiene. Important: if item 27 is marked other than "natural", or itsme 23s or 28s-f show any injury or other fraumatic syent, the Medical Examiner must be notified at ans. 1 ☐ Yes 2 X No Director Swanton MD Garrett 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21561 USA 4025 Bittinger Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Garrett Co. Roads Dept. Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Katherine Schroyer Joseph Andrew Fazenbaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4025 Bittinger Rd., Swanton, MD Hazel R. O'Brien/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery April 24, 2008 Accident, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. 1. X P.O. Box 275, Grantsville, MD mau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician wee /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien end for use es the buriel-transit The lew requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, an/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Physici 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be deteched 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably Inknown mentia 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has pege 2 certificate tal or Attanding Physician: T is efter deeth.

St Director: After this certificated in by the funeral director, pe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Natural 2 Accident 5 Pending 1 🗌 Yes investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours To the Funeral I the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified who completed cause of death (Item 23a) (Type, Print) 30. Name and address ouhland, Ud 2155 13079

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year VIOLET L. GAWEL 0955AM /Medical pnl 2002 -2 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Easton Eastor Talbox If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

JULY 27, 1920 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 □ M 2 1 X F MARYLAND 87 Director 216-10-1273 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f sh 1 Yes 2 No Director EASTON MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA 700 PORT ST., UNIT 4103 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: WHITE Completed by 3 XWidowed 4 ☐ Divorced 'natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HELEN BORGMANN AUGUST J. LUERS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 990 SUNSET VALLEY DRIVE, SYKESVILLE, MD 21784 WILLIAM GAWEL, JR/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 4/13/2008 STEVENSVILLE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Joseph SINUNG 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Due to (or as a consequence of) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine theorema ng physician and as the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Vear 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No P 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After the funeral bird of the funeral or by the funeral bird of the funeral bird o 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

Division or Vital Records, P.O. Box 68760.

Maryland 21215-0036

Baltimore,

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z U U S Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Пау Month Voor ELIZABETH 12 /Medical GROVES 04 08 9:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 V F Yrs. 218-38-0140 Director 92 November 23, 1915 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at Directo Maryland 1 X Yes 2 □ No Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 73 LaVale Court Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hyglene.
snt: If item 27 is marked other than "natural", or Items 23a or: Funeral 21502-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 € No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 2**X** No 1 🗌 Yes Completed by Specify: 3 Widowed 4 □ Divorced White Item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William DeVries 2 Mildred Laney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Groves 11 Tallowood Drive Glassboro New Jersey 08028-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillcrest Memorial Park April 17, 2008 Cumberland Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pulmonary acute disease or condition resulting in death) one da /Medical Due to (or as a consequence of) Examiner Atherosclaratic 24ew Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed the burial-transit Due to (or as a consequence of) attending physician Physician/Medical as for use a IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 obstructive Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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2 ☐ Accident 5 ☐ Pending investigation death. 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

P.O. Box 68760. Division or Vital Records, To the Hospital or Attending

within 24 hours after death To the Funeral Director:

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State Registrar

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29b. Signature and title of certifier

29c. License number 00055325

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BISHOP WALSH RD Cumberland MD21502 25

31. Date filed (Month, Day, Year) APR 1 5 2008

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Baltimore,	permit. Page Department Important: If any Injury of once.		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lic		Cedar	HIL	1 Cemet			-2006	Sulti	.anu,	mai y iand
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZUUT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death .Day 2008 **Physician** Rachel Luella Haines April 12, 4:35 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lorien at Taneytown Taneytown Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 11, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-01-3154 1 □ M 2 K F 1922 86 Maryland Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Director Carroll Taneytown 1 XYes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 314 Roberts Mill Road 21787 USA ms 23a must b Funeral ural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify: Completed by Specify white 3 Widowed 4 □ Divorced 'natural", Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natu .rry or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Worker Schools 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon E. Heffner Annie Condon P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garry Haines, son 4400 Ruggles Road, Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If I any injury or once, Trinity Lutheran Cem. 4/15/2008 Taneytown, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E. Baltimore Street, Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trar Due to (or as a consequence of) the attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2♣No certificate has autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No ၉ 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28d. Describe how injury occurred (Month, Day 1 X Natural Year) 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: within 24 hours after death To the Funeral Director: filled in by the

NJZ 5

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, and due nvestigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c, License number	29d. Date signed (Month, Day, Year)
Jum W modellyton	D21743	4/14/2008
30. Name any address of person who completed cause of death (Item 23a) (Type		
John Middleton 3337 VIC	tory Street M	1 ahchoto, MD21102
31. Date filed (Month, Day, Year) 32. Registrar's Signature		
APR 15 2008 March	1. 0.	

Medical

08-03026 John H. Hollman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

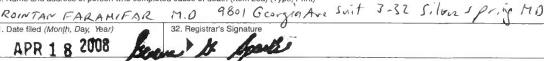
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	1-For State Certificate of Death Registrar Reg. No.								
Physici Medical Exam		Decedent's Name (First, Middle,Last) John H. Ho	llman				2. Date of Deal	th	3. Time of Death
icalcal Exam	mei	4a. Facility Name (if not institution, give street and num			lb. City, Town, or	Location of Deat	April 18, 2	4c. County of De	1614 hrs
		St. Agnes Hospital	- /		Baltimore			None	
Funeral Director		556 40 5022 1XM 2 F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		_	th (MM/DD/YYYY) 9.	Birthplace (State or Foreign Country) New York
, uny		Usual Residence of Decedent 10a. State 10b. County	10c, City, 7	Town or Location	on				10d. Inside City Limits
nd s how a	Ē	MD Baltimore		dlawn					1 Yes 2 X No
Maryland 28a-f show any d at once.	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What 0	
death with the Maryland or items 23a or 28a-f sho must be notified at once.		11 Bonnie Jean Court			2120	7		United	States
th with ems 2 t be n	Funeral	11. Marital Status 1 Never Married 2 Married Armed For	dent Ever in U.S		s Decedent of His es, specify Cuban	panic Origin? (S	pecify Yes or No		merican Indian, Black,
ter dea		3 Widowed 4 Divorced If Yes, Give Year	2 No 9	4/	Yes 2 X No		or trodin, oto.)		
ours af atu ral tamin	d by	or Dates: 15. Decedent's Education (Specify only highest grade		16a. Decedent	's Usual Decupat	ion (Give kind of	work done	Specify: V	hite ss/Industry
5-0036 led within 72 hours a Hygiene. other than "natura	Completed	Elementary/Secondary (0-12) College (1-	1 or 5+)		ost of working life.		tired)		
-003 I withi giene. ther the	omo	17. Father's Name (First, Middle, Last)		Electr	rical Eng		(E) . is in	Westing	house
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	John Charles Hollman				Helen G		Maiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type, Print)			Address (Stree	t and Number or	Rural Route Num	nber, City or Town, S	
MD and 2 sho saith and em 27 is		Phyllis A. Hollman/Wife 20a. Method of Disposition	Look D	11 Bon	nie Jear	n Court		n, MD 2120	
Baltimore, permit. Pages 1 an Department of He Important: If ite		1 Surial 2 Cremation 3 Removal from	n State cr	ematory or oth	er place)		Date	20c. Location - City	
Itim iit. Pa artmen ortant		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee			Mem. Par	ck 4-	23-2008	Eldersbu	rg, MD
Dep Dep Injuri		Hen Olli - With	1401(411	2 Old Co	olumbia	ry H. Wi Pike Ell	icott Cit	mily FH Inc. y, MD 21043
Physician		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.	sed the death. [Do not enter th	e mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition resulting in death)			vascular Dis	ease			Death
		Sequentially list conditions, Due to (or as a c	onsequence of):						
	iner	if any, leading to immediate Due to (or as a c cause. Enter Underlying Cause	onsequence of):						
d d	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a c	onsequence of):						
760, cate be executed physician and the burial - transit		d.							
760, Icate be ex physician the burial	Medical	UNPENDED AMENDED IF FEMALE: 23c, If yes, ou	tcome of pregna	2004				Look Barrell	
		23b. Was decedent pregnant in the past 12 months?	h	2 Feta	al death 3	Ectopic pregna	ancy	23d. Date of deli	very Day Year
Box 687 e death certific the attending ed for use as the	ysician/	1 Yes 2 No 9 Unknown 9 Unknown	nt at time of deat n	th 5 Oth	er (Specify)				
che the	y Phy	Part II. Other significant conditions contributing to c	eath but not res	ulting in the ur	nderlying cause gi	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
- S ig S	ed by	Diabetes Mellitus	7				1 Yes	2 No 3 F	Probably 4 🗸 Unknown
cord law req has bee	plet			-			24a. Was a autop:	sy prior	autopsy findings available to completion of cause of
Rec : The l ficate l	Completed						perfor 1 Y Yes		
Vital Rechysician: The this certificate	Be	25. Was case referred to medical examiner?	atient 2 🗸 E	R/Outnationt		of Death (Check		Residence 6 0	
of \ng Phy	<u>ان</u>	27. Manner of Death 28a. Date of		28b. Time of Inj		y at Work?		now injury occurred	ther:
sion ttendi death.	atio	1 Natural 5 Pending 2 Accident Investigation	ay, rear)		1 Y	es 2 No			
Division of Vital Records, ral or Attending Physician: The law requir rs after death. In Director: After this certificate has been seled in by the funeral director, page 2 should be a continued to the funeral director.	Certification:		of Injury - At hom	ne, farm, street	, factory, office bu	uilding, etc.	28f. Location (S or Town, St		Rural Route Number, City
Division of N To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.		29a. Certifier 1 Certifying Physician: To the best of	f my knowledge	, death occurre	ed at the time, dat	te and place, and	due to the cause	e(s) and manner as s	stated.
To the within To the comp	Medical	Medical Examiner: On the basis of and manner state	examination and	/or investigatio			at the time, date a		
	-	/ Valorlewo			29c. License O.C.N			29d. Date signed (i April 19, 2008	Month, Day, Year)
20 86	f	No_Name and address of person who completed cause Laron Locke MD. Assistant Medical B	,	,	Street, Baltim	IDEO MD 040	01	<u> </u>	
St	ate	31. Date filed (Month Pay Year)	trar's Signature		outel, pallim	UIE, IVID 212	· · · · · · · · · · · · · · · · · · ·		
Regist	rar	APR Z 1 2008 50	du s		163				
OHMH 17 Rev 1/20	01	0011		ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ror State Registrar<mark>Amend#29d,PerPhys,PCC4-18-08cr</mark> Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day 2008 John Joseph Hartnett /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Doctors Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. 1 🔀 M 2 🗆 F 76 Director Bethleham, PA 208-22-5608 4/15/1931 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director 1 ☑ Yes 2 ☐ No MD Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. Important: if firem 27 is marked other than "natural" ~ " any injury or other traumatic eventual." 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be in 7319 Longbranch Drive Funeral 20784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1949-1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify: ģ 3 Widowed 4 Divorced 1952 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Analyst Federal Employee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Timothy Hartnett Bertha Hein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Hartnett, Wife 7319 Longbranch Dr., New Carrollton, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Lakemont Memorial Gard. 4/15/2008 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Constance Jase Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration disease or condition resulting in death) unknown /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead as well.) Due to (or as a consequence of): Examine the death certificate be executed the burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 🔀 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No P 1 X Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d 4 Homicide 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1243446 4-11-081 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year) 2008



Registrar

		1 - For State Registrar	o (First Adiable Local		Marylar			of Health a	nd Mental Hy	Reg. No.	008	2 7-24	
Physici /Medic			ne (First, Middle, Las Inton Humbe						April	D	2008 ^{ear}	3. Time of 11:50	Рм
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		Goodwill	Mennonite	e Home			Grants	sville		Gar	rett		
Funeral		5. Social Security N			Age (In yrs.	last birthday,	If Under 1 Y	ear If Under 24	4 Hrs. 8. Date of B	irth	9. Birth	nplace (State or untry)	r Foreign
Director		214-28-70	J25	_M 2√2 F	7	7 Yrs.	INIONIUS	ays Hours	Feb. 1		31 Vir	ginia	
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28a-f	Director	MD 10e. Street and Nu	Garrett		Gr	antsvi	.11e	do		100 Citize	en of What Co	untar?	
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urs al	by	3 Widowed		If Yes, Give Year or Date			1 ☐ Yes 2X	No Specify:		S	Specify: W	hite	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "netural", or Iteme 23a or 28a-f ehow important: If them 27 is marked other than "netural", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, it is Medical Exaction from the indifficit at once.		19a. Informant's N	ame/Relationship (7	ype, Print)					or Rural Route Numi			(ip Code)	
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if its		1 🗆 Burial 2	☐XCremation 3 ☐		ate (cemetery, cre	matory or other	r place)			eation - City or Town, State OS Davidsville, PA		
t. Partmer			5 ☐ Other (Specify		Со	-							, PA
Depa Depa Impo eny is		21. Signature of Pt	uneral Service Licen	Peume	Wil			ddress of Facility	Newman F			s, P.A.	
		222 Part Enter	- / 1 ,						cantsville ardiac or respiratory		21536	Approximate	
Physician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)	art ailúre. List only o (Final on	a. Lu	h line.	anc	w.	aying, such as of	ardiac of respiratory	arrest,		Interval Bety Onset and D	veen
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the death ce y the attend iched for us	Physician/Medi	23b. Was deceden in the past 12 1 ☐ Yes 2 £ 9 ☐ Unknown	months?	23c. If yes, outcom 1 □ Live birth 4 □ Pregnan 9 □ Unknown	tattime of c	al death 3	□Ectopic pregn □ Other (specif			23	d. Date of deli Month		'ear
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 buors after death. with the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Completed by								perf	s an opsy formed? 2 No	prior to death?	topsy findings a completion of ca	available ause of
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oltal or Al urs after c arel Direct ited in by		3 ☐ Suicide 4 ☐ Homicide	determined	building,	etc. (Specia	fy)	reet, factory, of		City or To	own, State)		ra/ Route Numb	ber,
the Hosp nin 24 hor the Fune tpletely fi	Medical	29a. Certifier (Check only one)	2 Medical Exam	rsician: To the be iner: On the basi and manner	s of examina	owledge, deat ation and/or in	ivestigation, in	my opinion, death	place, and due to the occurred at the time	, date and p	lace, and due	to the cause(s)	
To To	2	29b. Signature and	Little of certifier	Bus	É	0		cense number	231		il 22,		
	8		ress of person who descell, M.I					zille. MI	21536				

State Registrar

31. Date fited (Month, Day, Year) APR 2

3 2008

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Acoust 1

32. Registrar's Signature

Amended #10c, nls, per fd, 04/16/08, Allegany Co. 1 - State Registrar Physi /Med Exam Funera Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

> Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death

14483

	1. Decedent's Name (First, Middle, La	ast)				2. Date of Deat		3. Time of Death
ian ical	ROSS	GARLAND		KELLER,	JR.	Month 04	1 ^{Day} 2008	0123 M
iner	4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town, o	r Location of Deat	n	4c. County of Deat	h
Samuel .	WMHS- BRADDOC	K CAMPUS		CUMBERLA	AND		ALLEGANY	
i r	215-26-9609	Sex 7. Age (In yrs	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 2,	0 D:	hplace (State or Foreign untry) yland
	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
Director	MD ALLEGAN			ET VIEW	CUMBERLA	AND.		1 □ Yes 2 Ki No
	10e. Street and Number 110 SUNSET VIEW			10f. Zip Code 2150	2	10	Og. Citizen of What Co USA	untry?
by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: WH	e, etc.
Completed	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or 5+)	i (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Business/	Industry
Sol	12	4			SAI	ES	JEWELER	
To Be	17. Father's Name (First, Middle, Las. ROSS GARLAND K					ne (First, Middle, N FAYE (LO		KELLER
	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, State, 2	Zip Code)
	GARY KELLER	BROTHER		OLEANDEI				
	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Themoval nom State		osition (Name of matory or other place of CMORIAL G			20c. Location - City or CUMBERLAND	·
	21. Signature of Funeral Service Lice			2. Name and Addre	ss of Facility HA		RAL SERVIC	E, P.A.
	23a. P rt1 Enter the disease, or or show, or heart failure. List only	nplications that aused the re	th. Do not en					Approximate
ı	Immediate Cause (Final disease or condition resulting in death)	a. Fr. d. Me	Co					Interval Between Onset and Death
	resulting in death)	Due to (or as a consec	quence of):	0	/	n Fauli		1
i e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):	Myo	ARCIOR	nthy		3 4 25
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
cal Ex	resulting in death) Last	Due to (or as a consec	quence of):					
ledi								
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	/		23d. Date of deli Month	ivery Day Year
y Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
q pe						1 □ Ye	s 2⊉No 3□Pr	obably 4 ⊡Unknown
Completed						24a. Was an autopsy perform	led? death?	topsy findings available completion of cause of
BeC	25. Was case referred to medical				26. Place of Dea	1 Yes 2 th (Check only one	No 1 □Yes	2 □ No
70 E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Anpatient 2] ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	ome 5 Reside	nce 6 ☐Other (Spec	cify)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred	
ertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, str	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
Medical Certification:	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exal	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the tire evestigation, in my control	ne, date and place opinion, death occu	, and due to the ca urred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Monti	n, Day, Year)
	> ///la	gremm			1221	81	April 11	2008
	30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Print)				
	GARY Wagos	rek 925	BIS	hop Wa	Ish Ro	ad, Cu	mberland	, Mary lack
ate rar	31. Date filed (Month, Day, Yell r) APR 1 6 20	08	to do	arte				2008 Maryland

DHMH 17 Rev 1/2001

State

Registrar

10 nu amend 10efg per K.H. h879 5/2/08 KH
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mahala Mayah 04 /Medical 4a Fecility Neme (If not institution, give street)and number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Meyer 14

If Under 24 Hrs. 8. Date of Birth
(Month, Dev.
(A - 18) corae If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days 10 M 202 F Months D Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1√DYes 2□No Howard ELLICOTI Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3193 Sonia Trail 21043 Funeral Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Haaith and Mental Hygiene. Important: If item 27 is marked other than "natural" and injury or other traumers. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Intany 0 B 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN Lalonia Moncries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) M) 21043 Mother 3193 LLICOH Donia Irail 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) HOSP DISDOCAL Prince Cteorac's HOSPITAL 23. Name and Address of Fecility 21. Signature of Funeral Service Licensee rince teorge 20785 3001 HOSDITAL sum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical PRE HATURITY EXTREME Examiner Due to (or as e consequence of): Physician/Medical Examiner RESPIRATORY DISTRES or Attending Physician: The law requiras that tha death certificate be executed attanding physician end if for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): STISIS Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by the pega 2 should be detached 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy 1□ Yes 2 1No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 DOA this funaral 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 1 Neturel 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by tha fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated. To the 29b. Signature end title of certifier 29d. Date signed (Month, Day, Yeer) 80 Hoedm mehnur 178186 30. Name end eddress of person who completed cause of deeth (Irem 23e) (Type, Print) Cheverly MD 20785 Dr Mehnur Abedin Drive 3001 31. Date filed (Month, Dey, Year) MAY 0 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 15 15 Mary Ella Magin 2008 5:35 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Summerville Nursing Home Westminster Carroll 8. Date of Birth Feb. 8, 1915 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Davs 1 □ M 2 🕱 F Hours Maryland 216-70-2499 93 Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or United States 3244 Ridge Road 21157 Funeral d 2 should be filed within 72 hours after dear th and Mental Hygiene. 7 is marked other than "natural", or items: traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XX0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXVo White Specify δ 3 XXVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Turner Haines Mary Wantz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 sl of Health ar if item 27 if Bonnie Swartzbaugh Daughter 3239 Ridge Road Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Taylorsville Cemetery April 18, 2008 Taylorsville, MD 4 □ Donation 5 Other (Specify) ^{22, Name and Address of Facility}
Burrier-Queen Funeral Home & Crematory,
1212 W. Old Liberty Road Winfield, MD 23a. Par 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of ock, or heart failure. List only one cause on each line. Immediate cause (Final Physician dis ase o condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death signed by the a 5 ☐ Other (specify) o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 2**%** No Very the russymmer of the russymmer of the Funeral Director: After this of the Funeral Director: After this of the funeral directors with the funeral directors. 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA P 6 Cother (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number è 29d. Date signed (Month, Day, Year) D25443 address of person who completed cause of death (item 23a) (Type, Print) 30. Name an Victory Street, Manchester MD21102 chn 31. Date filed (Month, Day, Year) APR 16 2008

Registrar

			State of Maryland 1- State amend #14 Per FH G879 5/15	1 / Depa /08	artment of F	lealth and Me Death	ental Hygier	008	14486				
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death				
	/Medic Examir	cal	Mary F. Mullinix 4a. Fecility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	4 1	3 0 2 4c. County of Deat					
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۱	Funeral Director		$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth Aug . 16,	1915 9. Birti	nplace (State or Foreign untry) MD				
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits				
	Marylan f show lied at	to			nster				1 ☐ Yes 2 ☐No				
	death with the Maryland ms 23a or 28a-f show frust be nullified at	al Direc	10e. Street and Number 703 Cherrytown Rd.		10f. Zip Code	2115 8	10g. (Citizen of What Co USA	untry?				
920	after or its	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 Ø No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Bleck, White Specify:					
21215-0036	within 72 hours iene. r than "natural", itip Maylcal Exe	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working		Nursing	·				
Maryland 2	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r freumatic event, Ita Med	To Be C	17. Father's Name (First, Middle, Last)		LSE	18. Mother's Name (First, Middle, Maid izabeth		ix				
Mary	nd 2 sho Ith and N 27 is ma r treuma		William Thomas Flynn Sr. 19a. Informant's Name/Relationship ype, nil)		•	and Number or Rural							
ore,	permit. Pages 1 end 2 Department of Health ar Important: If item 27 is any injury or other treu		1 Drawing 3 Comption 3 Demouslifrom State	ace of Dispos metery, cren	sition (Name of natory or other place	Da Da	te 20c.	Location - City or	Town, State				
Baltimore,	t. Pag rtment rtant: I njury o		`4 □Donation 5 □Other (Specify) How		hapeime	LII	/17/08	Long (Corner, MD				
Bal	permit. Departr Importa any inji	5	21. Signature of Funeral Service Licensee Ruhard Little	L		FH 34 Maj		Littles	stown, PA				
	Physician		23a. Part1. Enter the disease, or combilications that caused the death. shock, or heart failure. List only one cause on each line.		11				Approximate Interval Between Onset and Death				
	/Medical Examiner		adiate Cause (Final sase or condition ling in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): CARDIOMYOPATHIES										
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		7017	CHIE	>						
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68760	the the	dlcal	d										
P.O. Box (The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 21 No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of deli Month	very Day Year				
	w requires that is been signed by should be detailed	ed by Ph	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause giv	en in Part I.		v.	the cause of death?				
Il Records,	The law re ale has bee page 2 sho	Completed by					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of				
Vita	Physician: this certificaral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 25 No	P/Outpatien	t 3 DOA Oth	er: 4 Nursing Hom	(Check only one) 9 5 (Phesidence	6 Other (See	nife)				
n of	ing Phy After this uneral d	lon; To	27. Manner of Death 1. Natural 5 Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at 28	d. Describe how in		-my/				
Division of Vital	To the Hospitel or Attending Physicien: The law within 24 buous after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre		Yes 2 No	of, Location (Street City or Town, Sta		iral Route Number,				
	e Hospite 24 hours e Funerel letely fillex	Medical C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my know and manner stated.										
	To th within To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number	29d. C	Date signed (Month	n, Day, Year)				
	WIL		30. Name and address of person who completed cause of death (Item 2	23a) (Type, I	Print)	KINK (1	Litt	ctarri	-2008 PA17340				
		to	K. ACUNUGACAS Att. 31. Date filed (Month, Day, Year) 32. Registrar's Signatu	o) (o	いたろ	1	CAU (->10WN	11111240				
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 5 2008	J.	Coule								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month April 2008 Louise G Martin РМ 21:58 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Frostburg Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 94 **Director** MARCH 10,1914 MISSOURI 492-03-3834 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be marting once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #1 KAYLOR CIRCLE 21532 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Be Completed by Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS GERSHBOCK SARAH FADEM 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY ELLEN MARTIN / DAUGHTER 801 WASHINGTON STREET, CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State EASTVIEW CEMETERY 04/10/2008 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND, MD 21. Signature of Funeral Service Licensee UPCHURCH FUNERAL HOME PA 202 GREENE STREET, CUMBERLAND, MD 23a. Part1. Enter the diviase, or complica ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or a consequence of): 2 year /Medical **Examiner** A.S.C.U, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> obstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 2 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

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Registrar

WONSOCIC SMIN 9
31. Date filed (Month, Day, Year)
APR 1 0 2008

worsockellin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 BISHOP WALSH RD Cumberland MD 2/502

D0055325 | April 10, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** ROBERT DONALD MCALLISTER APRIL 16 8:48A /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar • 14,1930 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD Funeral **X**M 2□ F 215-34-4051 78 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Directo MD Frederick Frederick 1X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 Genesis Lane 21703 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X X o If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 is marked other the any fijury or other traumatic event, the angle. farmer farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil McAllister Blanche Trumpower 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Nicolet (Daughter) 6320 New London Rd., New Market, MD21774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State M☐ Buria 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Domation 5 ☐ Other (Solecity) Lutheran cemetery 4/19/08 Middletown, MD f Fun al Service I Bonald Adess of Thompson Funeral Home 21. Signature P O Box 18, Middletown, MD 21769 23. Part1 nter the dise that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Im rediate ause (Final disease or condition resulting in death) **Physician** Cattle MYDONTHULL intraction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-1 Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown COPI 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hypertension has autopsy performe page certificate 1 ☐Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier

Box 68760. P.O. | Division or Vital Records,

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

MD

Thonson

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

Hiren Shoh

32. Registran Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 1 8 2008

				artment of Health and M tificate of Death	lental Hygi	ene g. No. 2008	14489
	Physic		1. Decedent's Name (First, Middle, Last) Benjamin F. Mason, Jr.		2. Date of Death Month April	1 ^{Day} , 200 ^{Year}	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give street and number) 9106 Lela Court	4b. City, Town, or Location of Death Fort Washingto		4c. County of Death Prince G	7:25 AM
100	Funeral Director		5. Social Security Number 231-05-3099 6. Sex 1 7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day, 09-12-	9. Birtho	lace (State or Foreign try) ge, VA
	Maryland f show ied at	jo	10a. State 10b. County 10c. City, Town or Lo	shington		1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the	Funeral Director	10e. Street and Number 9106 Lela Court	10f. Zip Code 20744	10	g. Citizen of What Coun	try?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I fiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once.	by	1 ∐ Never Married 2 2 Married 1 2 Yes 2 ☐ No A L RLy	Use Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto □ Yes 2☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of SpecifyBlac	etc.
Maryland 21215-0036	ed within 72 he giene. er than "natui , the Medical	Completed	(Specify only highest grade completed) (Give	ent's Usual Occupation kind of work done during most of worki O NOT use retired) ter-Designer	ng :	6b. Kind of Business/Inc Defense M gency - D	apping
yland	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) Benjamin Franklin Mason, Sr.	18. Mother's Name Maggie	Anna J	ames	
e, Mar	and 2 sh lealth and m 27 Is m her traum		19a. Informant's Name/Relationship (Type. Print) Margaret Settles/ Daughter 9106			City or Town, State, Zip • , MD 207	Code) 4 4
Baltimore,	t. Pages 1 tment of h tant: If ite		4□Donation 5□Other (Specify)	coln Cem. 04-1	L6-08 B:	oc. Location - City or To rentwood,	MD
Bal	Depar Impor any Ir		fully should 65	Name and Address of Facility Str 00 Allentown Ro	d, Camp	Springs,	MD 20748
	Physician /Medical / wascian and prival-transit the prival-transit	ical Examiner	any, leading to immediate cause. Enter Underlying		ıse	rt,	Approximate Interval Between Onset and Death
P.O. Box 687	ath certific ttending p or use as	Physician/Medic		Ectopic pregnancy Other (specify)		23d. Date of deliver	ry Day Year
rds, P	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.		cco use contribute to the	e cause of death? ably 4 □Unknown
Vital Records,	sician: The law re certificate has be irector, page 2 sho	Be Completed	25. Was case referred to medical	26. Place of Death		prior to con	sy findings available pletion of cause of 2
= :	i di di	유	examiner? 1	3 DOA Other: 4 Nursing Hom 28c. Injury at Work? M 1 Yes 2 No	ne 5 Residenc 8d. Describe how	et and Number or Rural	
Totion Louis of	within 24 hours a vithin 24 hours a completely filled i	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of dertifier	estigation, in my opinion, death occurred	ed at the time, date	se(s) and manner as state and place, and due to	the cause(s)
P	(10)	1	30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint) 16525		4/14/0	4
	Sta Registra		Dr. Andre Michaelak 1140 Varnum St. N. 31. Date filed (Month, Day, Year) APR 1 8 2008 32. Registrar's Signature	Ê. #2088 , W45h; D	.C. 2001	+	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Day Year Susan Louise Mehn 04 21 2008 2:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dennett Road Manor Nursing Home Oakland Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/23/1961 **Funeral** Birthplace (State or Foreign
Country) Months Days Hours 1 □ M 2 🗙 F 171-54-0401 Director 46 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State ms 23a or 28a-f show r must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 √ Yes 2 □ No MD Garrett Mt. Lake Park 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Pleasant View Drive 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3 ☐ Widowed 4 ☑ Divorced "natural" White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 11 th Hairdresser Beauty Salon Department of Health and Mental Hygie Important: If item 27 is marked other I any injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Cheke, Sr. ဂ Barbara H. Fazekas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaina Evans / Sister 485 Brant Road Swanton, Maryland 21561 20b. Place of Disposition (Name of cemetery, crematory or other place. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Omega Crematory 4/23/2008 Morgantown, WV 21. Signature of Funeral/Service 22. Name and Address of Facility Stewart Funeral Home 32 South Second Street Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ute Physician /Medical **Examiner** Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, physician the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy certificate l 1∐ Yes funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only on 1 ☐ Yes 2 No Other: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural
Accident 5 ☐ Pending investigation s after dea. 1 Tes 2 □ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number ss of person who completed cause of death (Item 23a) Type, Print) 13079 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State APR 2 4 2008 Registrar

Amended Item #8 per FH, 4/25/08 kso Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month John Edward Miller April 2008 1:20 16 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 0akland Garrett County Memorial Hospital Garrett If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 1/25/35 9. Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**⊠**M 2□ F Director 214-32-3244 July-19--1935 Maryland Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits **Moy** item 27 is marked other then "natural", or items 23a or 28a-f eho: other treumstic event, the Mudical Examinar must be notified at 1X Yes 2 □ No Director Garrett 0akland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 E. Water Street 21550 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: 3 ☐ Widowed 4 K Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 MD State Roads Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Hant: If item 27 is marked of Theoda Rice 2 John Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nowell Simmons, P.R. P.O. Box 2067, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny Injury or ot 4/19/2008 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory Oakland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. Ratherine Sweeter 21 N. Second St., Uakland, MD 21550 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alcoholic Cirrhosis vrs /Medical Due to (or as a consequence of): Examiner Hepato Renal Syndrome days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) deteched ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ page 2 should be Be Completed Severe Anemia 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause ol death? 24a. Was an Gastrointestinal Bleeding this certificate hes autopsy 2 X No 2 No 1 ☐ Yes After this certification funeral director, i or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 X Inpatient 1 ☐ Yes 2 X No Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 5 Pending death. investigation 1 Yes 2 No I Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. no title of certif 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D23979 April 16, 2008 person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Dr. Robert A.

APR 1

7 2008

31. Date filed (Month, Day, Year)

Goralski

32. Registrar's Signature

311 N 4th Street, Oakland, MD 21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4-26-2008 **Physician** 7:00 P Mitchell Joseph Nytko Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 TT 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 12-27-1927 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours IL 351-20-2923 80 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mydical Examinar must be notified at 1 Yes 2 □ No Director Frederick Frederick MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 239 East 6th Street 21701 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: White 合 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7?
Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "nr any injury or other traumatic event, Ite Media once. Elementary/Secondary (0-12) College (1-4or 5+) Hahn Electric Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Nytko Agatha Kocal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Krueger 237 East 6th St. Frederick, MD 21701 Step Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2008 Lewistown, MD 4 ☐ Donation 5 ☐ Other (Specify) Prospect Cem. 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service M01176 106 East Church St. Frederick MD 21701 3a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest strick, or heart failure. List only one cause on each line. Chroni Immediate Cause (Final Physician disease or condition resulting in death) /Medical Preumonia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed ending physician and use as the burial-trar Due to (or as a consequence of) P.O. Box 68760% Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown is been signed by the should be detach€ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Ś 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my online, death occurred at the time, date and place. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi 00062223 completed cause of death (Item 23a) (Type, Print)

8x,

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person with

Bolarum M.D. 196 T.J. Drive Frederick, Maryland 21702 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4, 2008 Month 9:54F Edgar Paul Neal 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 1**X**M 2□ F 218-03-1495 Virginia Jan. 4, 1917 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2X No Freeland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1607 Freeland Road 21053 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plastics Mfg. Die Setter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Neal Dora Bell Noe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earline N. Neal, Wife 1607 Freeland Rd., Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 29 1 Burial 2 □ Cremation 3 □ Removal from State Middletown Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Freeland, MD 2008 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Sign ture of Funeral Service License tarlens le 24 Second St., New Freedom, PA 17349 #art1. Boter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY ARREST SECONDARY TO ASPIRATION disease or condition resulting in death) Due to (or as a consequence of): INFARCTION MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform 1∐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 RER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, attending physician the signed by the at d be detached fo has page 2 or Attending Physician:

Completed by Physician/Medical Examiner certificate After this s after dec. ral Director: Aft filled in by To the Hospital or within 24 hours aff To the Funeral D

Be

Certification: To

Medical

29a. Certifier

Physician

/Medical

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

the Medical

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant; If Item 27 is marked other than ury or other traumatic event, the Me

Department of Health Important: If Item 27 any injury or other tr once.

Physician

/Medical

death v

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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29b. Signature and title of certifier

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

D64300

ourtner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> OSLER DRIVE TOWSON, MARYLAND 21204

24.2005

Registrar

Kounte

and manner stated

Division or Vital Records, P.O. Box 68760, or Attending Physician: after death π 24 hou. •• Funeral Γ

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D0061882

April 12, 2008

State Registrar

Ira Yale Rabin, MD Holy Cross Hospital, 1500 Forest Glen RD. Spring, MD 31. Date filed (Month, Day, Yea 32. Registrar's Sign APR 1 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

						Certificate of	Death	F	leg. No.	10 14495
	Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of Dea		3. Time of Death
	/Medic		PATRICK	OBRIEN	!			APRIL	15 ^{Day} 200	
1	Examir	er	4a Fecility Name (If not institution, give	•			4b. City, Town, or I		,	of Death N/A
			1632 Inverness 5. Social Security Number 6. So		(In yrs. last birtl	nday) If Under 1 Yea		imore		Birthplace (State or Foreign
15.	Funeral Director			DeM 2□ F		rs. Months Days	Hours Min.	8. Date of Birth Month, Day OCT 20,	1947	Maryland
	/land		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Many Ined	ţo	Maryland N/A			Baltimore				Yes 2□No
	th the	irec	10e. Street and Number			10f. Zip Code		1	10g. Citizen of W	het Country?
	th will	ai	1632 Inverness A	venue			21230		USA	
Baltimore, Maryland 21215-0020	s 1 end 2 should be filed within 72 hours efter death with the Maryland f Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdcal Examinar must be not the death.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 MDivorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No		pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. White
5.	natu den	etec	15. Decedent's Ed (Specify only highest gree	ucation de <i>completed)</i>		Decedent's Usual Occu Give kind of work done	during most of wor	king	16b. Kind of Bus	siness/Industry
121	within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retir	ed) -		Elect	rical
d 2	filed v Hygie ther t		17. Father's Name (First, Middle, Lest)	1	16	chnician	18 Mother's Nan	ne (First, Middle, i		
an	d be antal	o Be	James Melvin	O'Brien				e Ann We		"
ary	d 2 should be filed within h and Mental Hygiene. 7 Is marked other than " traumatic event, the Mas	ဍ	19a. Informent's Name/Relationship (7		19b.	Mailing Address (Stree				State, Zip Code)
Σ	Health a Health a tem 27 is		Nicole K. O'Brien/		361	.8 Keystone	Avenue E	altimore	e, MD 21	211
Ore	of He of He litem	Ì	20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other plants	ace)	Date	20c. Location - 0	City or Town, State
<u><u>E</u></u>	Pag nent ant: If ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		A11 Coun	ty Cremation	Service	4/16/2008	3 Sykes	sville, MD
Balt	permit. Pages 1 end 2 Department of Health i Important: If item 27 is any injury or other tra pnce.		21. Signature of Funeral Service Licens	Imald		Haight Fu	ess of Facility Ineral Hon 195 Sykes	ne & Char sville. M	oel, P.A MD 21784	(410-795-1400)
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the cause on each line	he death. Do no	ot enter the mode of dy	ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)		EPATO CO	EUULAR onsequence of):	CARCINO	OMA		Onset and Death
	cuted nd ransii	Examiner	Sequentially list conditions.	b	ue to (or es a co	onsequence of):	•			
Ö,	e exe ian al unal-t	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Box 68760,		Med	that initiated events resulting in death) Last	d	ue to (or as a co	nsequence of):				
-	death le atter ed for u	sicia	Part II. Other eignificant conditions co	ntributing to death but	not resulting in t	the underlying cause g	iven in Part I.	23b. Did to	becco use conf	tribute to the ceuse of death?
P.0	ires that the death cer signed by the attendir d be deteched for use	Physician						1□ Y	es 21 No	3 Probably 4 Unknown
Ś	res th	ፍ								
Vital Record	law requires es been sign 2 should be	Completed						24a. Was a perfori		24b. Were autopsy findings available prior to completion of cause of death?
<u>=</u>	The law sate hes b page 2 s	5						10 W	5 2ZNo	1 ☐ Yes 2 ☐ No
<u>Zita</u>	cian: ertific	Re	25. Was case referred to medical examiner?	sa sakan				th Check only on	e/	
of	hys his al di	0	To res Zp No	T	2 ER/Outp	atient 3L DOA		ome 5 Reside		
u O	ding Phy h. After thi funeral	0	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Tir Inj	ury Wo	iryet ork?]Yes 2∐No	28d. Describe ho	ow injury occurre	,d
Division	l or Attending after death. Director: After d in by the fune	ica 	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injun	/ - At home, fam	n, street, factory, office		28f. Location (St	reet and Numbe	or or Rural Route Number,
<u>S</u>	after after Direct d in by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	., 51.551, 125.51, 51155		City or Town	n, State)	3 1 13 2 1 1 3 2 3 1 2 1 3 3 3 3
	he Hospi in 24 hou he Funer pletely fil	edical	29a. Certifier 1 Certifying Physical (Check only one) 1 Medical Exemi	sicien: To the best of a ner: On the basis of ea and manner state	xamination and/	death occurred at the to investigation, in my	ime, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and man ate and place, ar	nner as stated. nd due to the cause(s)
	11).TL	200	29b. Signature and title of certifier	, 7	rysician	29c. Licen		507	APRIL	(Month, Dey, Year)
	8		30. Name and address of person who co	ompleted cause of dea	th (Item 23e) (T	ype, Print) LINIVER	DOOGE	RYLAND	BAUTIM	ione, MD
			NAIMISH PANDYA	MD	0:	22 5	GREENE	Sir.		21201
	Stat Registra	.	31. Date filed (Month, Day, Year)	32. Registrar's	-	1				
	negistra		APR 16 2	UUX RICHE	we for	Sparke				

Amended #20b, nls, per fd, 04/16/08, Allegany Co. **Physician** /Medical Examiner **Funeral** Director

permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

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Examiner

Completed by Physician/Medical

Medical Certification: To Be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar		State of Ma	•	epartment of F Certificate of			iene _{9. No.} 2 (008	14496
	e (First, Middle, Last))				2. Date of Deatl			3. Time of Death
	MA	RY GERTR	HDF	PRICE		Month 04	Day 1.3	Year 08	0028 ^M
4a. Facility Name (/	If not institution, give		.001		Location of Death	04	T	y of Death	0020
WMHS-BI	RADDOCK CA	MPIIS		CUMBERI			ALLE	CANV	
5. Social Security N			e (In yrs. last birt		If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
235-80-7	/939]M 2XF	84	rs. Months Days	Hours Min.	(Month, Day, 1-24-1	924	Coun	MD MD
Usual Residence of 10a. State	f Decedent 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
PA	BEDFORD		HYNDM	AN					1 Xves 2 No
10e. Street and Nu	mber			10f. Zip Code		10	g. Citizen of	What Coun	try?
137 TH	IRD AVE.			15545			USA		
11. Marital Status		Was Decedent E Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ	
1 □ Never Marr 3 🛣 Widowed	ried 2 ☐ Married 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates;	10	1 □ Yes 2X No	Specify:		Specia		
	15. Decedent's Edu cify only highest grade		16a.	Decedent's Usual Occup	ation		 16b. Kind of B		
Elementary/Seco		e completed) College (1-4or 5		(Give kind of work done of life. DO NOT use retired	during most of work ()	ing			
12				Homemaker	40.44		OWN H		
	(First, Middle, Last) E A。 NELSO	N			18. Mother's Name ANNA BAI		faiden Surnai	me)	
	ame/Relationship (Tv.		106	Mailing Address (Street			City or T-	State 7	Cadal
	A. FOX/ D	,		72 BOX 395			only or Lown	, state, Zip	0000)
20a. Method of Disp		AUGHIER		Disposition (Name of y, cramatory or other place Cemetery			20c. Location	- City or To	wn, State
	☐Cremation 3 X R 5 ☐ Other (Specify)	temoval from State	1	•		2000		37 13 4	
	uneral Service Licens	91 +	_HYNDMAI	22. Name and Addre			HYNDMA ZETGLE		ERAL HOME
Mu	omytva	Trille		169 CLAREN					EIGHL HOFIL
23a. Part1 Enter t	he di e se, or comp art fa i e. List only or	cations that caused ne cause on each lin	the death. Do n	ot enter the mode of dyin					Approximate Interval Between
Immediate Cause disease or condition	(Final	MY	OCAR	DIA 10	FARC	Tlux			Onset and Death
resulting in death)		Due to (or as a	a consequence o		1 21/1				1-1/1
Sequentially list co	nditions,		2 00000 110000	£1.					
cause. Enter Unde Cause (Disease or that initiated events	erlying	Due to for as a	a conse juence o	7					
that initiated events resulting in death) I	Last C	Due to (or as a	consequence o	f):					
		1							
IF FEMALE: 23b. Was deceden	t pregnant	3c. If yes, outcome p		3 □Ectopic pregnancy				ate of delive	•
in the past 12	No	4☐Pregnant at		5 Other (specify)			M	onth	Day Year
9 ☐ Unknown		atributing to death bu	it not reculting in	the underlying cause give	on in Dort I	23a Did tob	2002 1100 020	tributa to th	e cause of death?
AL	ZHEIN	-)15 E		arm raut.	1 ☐ Ye		3 ☐ Prob	
		, ,	,			24a. Was an	246	Moro outo	osy findings available
						autopsy	/	prior to cor death?	npletion of cause of
25. Was case refer	red to medical				26. Place of Death	1□ Yes	No	1 🗆 Yes	2□ No
examiner? 1 ☐ Yes	/	lospital:	nt 2 RER/Out	patient 3 DOA Other		me 5 ☐ Reside		her (Snecifi	·)
27. Manner of Deat		28a. Date of Injur (Month, Day	y 28b. Ti			28d. Describe ho			7
1 Natural2 Accident	5 Pending investigation	(World), Day	rear) III		Yes 2 □ No				
3 ☐ Sulcide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of inju building, etc	ry - At home, far :. (Specify)	m, street, factory, office		28f. Location (Str. City or Town,		ber or Rura	Route Number,
29a Cortifica	1 Cortifuina Dh.	sician: To the best o	if my knowledge	death popured at the Vi	no date and -!	and due to the	wee(5) - '		
29a. Certifier (Check only one)	2 Medical Exami	ner: On the best on ner: On the basis of and manner sta	examination and	death occurred at the tin	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mate and place,	anner as st , and due to	ated. the cause(s)
29b. Signature and	title of certifier	۱ ،		29c. License	number	29	d. Date signe	ed (Month, i	Day, Year)
> 4	eyen P. 1	sulling.	R	D-	34812		24/14	1/08	
30. Name and addr	rese of person who co	mpleted cause of de		rive Cur	herla.	I Ma-	ulan.	1 2	1502
31. Date filed Mon	th, Day, Year)	32. Redistra	r's Signature	1 4	- DCI TOM	/	1100	~ ~	
V	WALK 1 6 51	JUB DUE	we St.	Boarde					

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State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** 2150 P M Doris Jean Roland April 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Cecil If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕅 F Director 232-70-5424 63 April 11, 1945 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Examiner must be notifled at 1 ☐ Yes 2 X No Director Maryland Ceci1 Rising Sun 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ō 21911 Items 23a 177 Sylmar Road United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced "natural", White the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M Homemaker In Her Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ray Collins Emma Hagerman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Montgomery/Daughter 169 Sylmar Road, Rising Sun, MD 21911 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 29 permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 □ Cremation 3 □ Removal from State Little Britain Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Peach Bottom, PA 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) MYOCAKOIAL INFARCTION HOURS /Medical Due to (or as a consequence of): Examiner YEARS CORONACK ANTENY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diss to for as a consection of Examiner YEARS HYPERTENSION Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be exer Division or Vital Records, P.O. Box 68760, physician Physician/Medical INSULIN DEPENDANT DINBETES attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) I ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 1 No 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAR-EL 31. Date filed (Inv.) Data Year 2008

304-106 NOKTH STREET

11 TF 000 D

SUITE #3

April 25, 2008

ELICTUM MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Richard Shannon Ray, Sr. April 14 2008 /Medical 1:48 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 577-34-4049 **Director** 78 6, _1929 Washington, D.C. Nov. Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director Maryland| Anne Arundel 1X Yes 2 No Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1702 Spring Green Avenue 21114 S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1♥]Yes 2□No IfYes, Give Year or Dates:1948-152 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 12 should be filed w h and Mental Hygiei 7 is marked other th Vice President Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked on any injury or other traumatic ev John Ray Marguerite Shannon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Ray / Daughter 1702 Spring Green Avenue, Crofton, Maryland 21114 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/2008 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery
22. Name and Address of Facility Robert E. Evans Funeral Home Gardens 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Smail Physician Cell months Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 1 Tyes 2 2 ER/Outpatient 3 DOA 27. Manner of De ith Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Hospital or Attending the Funeral Director: A

Medical completely the 0 State

29a. Certifier

(Check only one)

29b. Signature and title of certifier cenere were, Mis

1ª7 2008

29c. License number DSZ830

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

APCIL 14,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Bestgate Rood # 30, Annapolis, MD 21401 MO 900

			For State Registrar	State of Marylar	-	artment of H		-	giene Reg. No. 2	008		+99	
ì	Physicia /Medic Examin	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	2. Date of Death Month Day Year 3. Time of De				
			Melissa Ann Rotunn 4a. Facility Name (If not institution, give st.	4b. City, Town, or	Location of Deat	April	1	nty of Death	4:00 P M				
		ier	2523 Kitmore Lane	Bowie	Location of Deat			rince George's					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th .	9. Birth	place (State or	Foreign	
	Director		272-78-4559	^{M 2} K F 42	Yrs.	Months Days	Hours Min.	May 28	, 1965	Ohi			
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	cation					I0d. Inside City	Limito	
		ō				odion					1 X Yes 2		
		Director	Maryland Prince Ge	orge's Bow	rie	10f. Zip Code			10g. Citizen o	of What Cou	ntry?		
		٥	2523 Kitmore Lane			20715		I	JSA		,		
	ms 2:	Funeral		2. Was Decedent Ever in U	J.S. 13. \	Was Decedent of Hi	spanic Origin? (S	Specify Yes or No	- 14. R	ace - Americ			
0	after or Ite	Fu	1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		no Rican, etc.)		lack, White,	etc.		
200	ural",	d by	3 Widowed 4 Divorced	Year or Dates:					Spec	Wh	ite		
2	"natu	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	lurina most of wo	orking	16b. Kind of	Business/In	dustry		
7	withir ene. than he M	뻝	Elementary/Secondary (0-12)	College (1-4or 5+)	Home 1		,		Own Ho	me			
7	Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)		1.220.0		18. Mother's Na	me (First, Middle,	Maiden Surn	ame)			
g	2 should be and Mental Is marked (raumatic ev	9 9	Otto William Rotun	no			Karen Ly	ynn Kenne	edy				
a			19a. Informant's Name/Relationship (Type		1	ng Address (Street a			-		Code)		
ž ú	Health tem 27 l		Daren C. Rotunno/ B			8th Stree	t N.E. V	Vashingto Date					
2	ages int of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, cren Metro	natory or other plac opolitan	θ)	15/2008	20c. Location	-			
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra	- 3	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	<u> </u>		matory 2. Name and Addres	-		Alexan				
Ö			1 pefknik	5		6000 Anna					ai nome		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician		Immediate Cause (Final disease or condition a Metastatic Breast Cancer 4 Years										
	/Medical Examiner		Due to (or as a consequence of):										
		e	Sequentially list conditions, b. Due to (or as a consequence of):										
		Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events c.										
5	be executed ician and burial-transit	Exc	resulting in death) Last Due to (or as a consequence of):										
00/00	cate b	dical	d.										
Y .	death certifica attending ph	/Мес	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □ TWo □ TWO □ T							22d Date of delivery			
מ	atten d for u	sician/M								23d. Date of delivery Month Day Year			
į	The law requires that the death certificate ite has been signed by the attending physoage 2 should be detached for use as the	5	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	9□Unknown									
'n.	ss tha gned I	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?				
5	w requir been si should t								1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown				
נו	law r las be	Completed						24a. Was	osv .	b. Were auto	ppsy findings av	vailable use of	
	sician: The law certificate has b irector, page 2 s	Con						perfo 1☐ Yes	rmed? 2 X No	death? 1 ☐ Yes	2□No		
2	certifi ector	Be	25. Was case referred to medical examiner?	spital: 1 ☐ Inpatient 2 ☐		t 3 DOA Othe		ath (Check only c					
5	To the Hospital or Attending Physician: The kawitin 24 Hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2	: To	1 ☐ Yes 2 XNo 27. Manner of Death	4 🗆 Nursing i	rsing Home 5 X Residence 6 Other (Specify) 28d. Describe how injury occurred								
5		Certification:	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	? Yes 2 ∐ No	Loui Boodiibo i	iow injury coo	dired			
<u> </u>		ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	eet, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
5	ital or rrs afte ral Dir	Cert											
	a Hosp 24 hou Fune etely fi	Medical	29a. Certifler (Check only one) 29a. Certifler (Check only one) Check only one Check										
	To the To the Complete	Me	29b. Signature and title of eartifier	29c. License number			29d. Date signed (Month, Day, Year)						
)	10 8		1	D0033293			4/14/2008						
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Smith, M.D. 5454 Wisconsin Avenue Chevy Chase, MD 20815										
	box		Frederick Smith, M. 31. Date filed (Month, Day, Year)	D. 5454 Wis	consin	Avenue C	nevy Cha	ase, MD 2	20815				
	Sta Registr		APR 1 7 200	32. Jegistrar's Signa	J. A	mede							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician KENNETH 04 08 11:02 ROBINETTE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS ALLEGANY CUMBERLAND 8. Date of Birth (Month, Day, Year) Sep 13, 1914 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Director <u> 235-10-8219</u> 93 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Allegany LaVale MD 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the M. clcal Examiner must be r 21502 USA 300-K National Hwy. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Air Force 12 Chief Master Sergeant marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 Is marked out Be Myrtle Mae Brotemarkle Robinette James R. Robinette 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

190. Macro Street Sequin TX 78155 19a, Informant's Name/Relationship (Type, Print) Seguin daughter Janet Wolber or other Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Page Department o Important: If any Injury or 1 □ Burial 2 □ Cremation 3 □ Removal from State 4/19/2008 Sunset Memorial Park MD Cumberland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Liberts 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a, Part T. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease condition resulting in death) BILATERAL **Physician** PNEUMONIA ONE WIER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) Box 68760. physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a I Yes 2 □ No P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, PRESSURE HEAROCEVARUS - SEVERE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CONVESTIVE HEART FAILURE - ACUTE AND CHRONIC nas autopsy TRACT INFECTION certificate URINART 1∐ Yes 2 XNo or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 funeral (28a. Date of Injury (Month, Day Year) 28b. Time of Injury To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 14 TIT, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTLAND 21502 1068 NATIONAL HIGHWAY LAVALE IMMES R. MOEN MD 31. Date filed (Month, Day, Year) State Goods APR 1 7 2008 Registrar